MOUNTAIN ORTHOPAEDICS

R PEPPER MURRAY, MD | JOHN C EDWARDS, MD | ERIC C JOHNSTON, MD | STEVEN B HUISH, MD
JOSHUA M HICKMAN, MD | JARED J TYSON, MD | CLINT J WOOTEN, MD | CHRISTOPHER S ENGLISH, MD
MICHELLE PEPPER, MD | TRAVIS M HENDRY, MD | BRIAN D POWELL, MD | PAUL J. JOHNSON. MD

Please complete this form as accurately as possible. This information is important in planning your care. We will be happy to assist you as needed.

Date: _____ Name: _____
Age: _____ Occupation: _____
Employer or School: _____ Year in School: _____
Primary Care Physician:_____
Who referred you to us: _____

Please describe why you are here to see the doctor by filling in the following blanks. **Dominant hand: Right or left**

R or L: _____ _____ _____ _____
What Body Part is injured? | Pain / swollen / weak / unstable | Date this began? | Where injured? Work/school/other

HPI Describe in detail how this began: _____
_____
_____

Describe treatments you or your doctor have tried (medicines, ice, brace, therapy, which doctor:
_____
_____

Sports / Activities you enjoy:_____

PMHx List all medical problems you have had. (e.g. high blood pressure, diabetes, asthma, heart, etc.):
_____
_____
_____

PSHx List all surgeries and year. (e.g. appendix 1956, heart bypass 1995, knee scope 1980, etc.):
_____
_____
_____

MEDs List all medication you are taking. Include insulin and other injectables:

Medication	Dosage (mg strength)	How often you take this medicine?
		AM / PM / OTHER
		AM / PM / OTHER
		AM / PM / OTHER
		AM / PM / OTHER
		AM / PM / OTHER
		AM / PM / OTHER

OFFICE USE ONLY
_____
_____
_____

Allergies List all allergies to medications and identify your reaction:

Medication	Reaction (circle)
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious

Circle any other allergies: Shellfish IV Dye Latex Tape Other: _____

Family Hx List any medical problems that run in your family (i.e. arthritis-mom, heart disease-grandpa, prostate cancer-uncle): _____
_____

Social Hx Marital Status: _____

If you are ill or recovering from surgery, is there someone to assist you at home? Y / N

Number of children at home: _____ Number of children out of the home: _____

How much do you smoke? _____ How much alcohol do you drink? _____

ROS Circle any problems you have ever had:

Stomach Ulcers
Blood Clots
Unusual Bleeding
Cancer or Tumors
Diabetes
Heart Problems
High Blood Pressure
Chest pain or Angina
Mitral Valve Prolapse
Recent weight gain > 20 lbs.
Recent weight loss > 20 lbs.
Sleep Disorders (apnea, snoring, etc)
Prednisone Use
Kidney Problems
Liver Problems
Hepatitis / Jaundice
Asthma
Other Lung Problems
Stroke
Seizures
Depression
Pacemaker

This information is true to the best of my knowledge. _____
Patient or Guardian Signature

OFFICE USE ONLY

Height: _____ ft. _____inches Blood pressure: _____/_____

Weight: _____ lbs. Pulse: _____

BMI: _____ Underweight: BMI < 18.5 Overweight: BMI = 25-29.9
Normal weight: BMI = 18.6-24.9 Obese: BMI > 30

Nurse: _____ Physician: _____