Bear Lake Orthopeadic

Name_____ Date of Birth____/____/____

Today's Date _____ What are we seeing you for today?_____

How did it happen? _____

Date of injury _____ X-rays taken? **YES / NO** Prior treatment? **YES / NO**

Primary Care Physician _____ Referring Physician_____

Drug Allergies _____

Current Medications/dosage _____

_____

Hospitalizations/Surgeries_____

_____

Review of Symptoms

Please circle if you are now experiencing any of the following:

Fever/Chills	Vomiting	Diarrhea	Constipation
Night Sweats	Bladder incontinence	Blood in stool	Numbness/Tingling
Palpitations	Abdominal pain	Chest pain	Joint pain
Wheezing	Bowel incontinence	Headaches	Shortness of breath

Other:_____

Lifestyle

Occupation:	Alcohol use: **Yes / No** **If yes, amount per day**_____	Tobacco use: Smoke / Chew **Quanity per day**_____
Exercise: o Less than 1 time per week o 1 to 3 times per week o 4-7 times per week o daily	Type of exercise: o Running o Biking o Aerobic o Weight training o Other_____	Diet: o Fairly balanced o Eat too much o Lots of fast food o I follow a diet program
Second hand smoke **Yes / No**	Recreational Drug use: **Yes / No**	Addiction Help: **Do you need a doctor's help with drug addiction?** **Yes / No**

Name -_____

Please circle if you have a medical history of the following:

Anemia	Anesthetic problems	Arthritis	Asthma
Blood clots	Cancer/ what kind?_____		Infections
Gout	Digestive disorder	Acid reflux	Ulcers
Ulcerative colitis	Depression	Heart disease	Hepatitis
Heart problems	Heart surgery/what kind?_____		Pneumonia
Heart attack/how many?_____ When?_____		High blood pressure	Diabetes
Kidney disease	Osteoporosis	Stroke	Epilepsy
Latex allergy	Tuberculosis	Mental illness/attempted suicide	
Thyroid disease			

Women

Pregnant	Planning Pregnancy	Nursing

Family History

Please check circle if you have a family history of the following:

Heart Disease?	High Blood Pressure?	Cancer?	Arthritis?
o None	o None	o None	o None
o Father	o Father	o Father	o Father
o Mother	o Mother	o Mother	o Mother
o Mother's Father	o Mother's Father	o Mother's Father	o Mother's Father
o Mother's Mother	o Mother's Mother	o Mother's Mother	o Mother's Mother
o Father's Father	o Father's Father	o Father's Father	o Father's Father
o Father's Mother	o Father's Mother	o Father's Mother	o Father's Mother
o Brother	o Brother	o Brother	o Brother
o Sister	o Sister	o Sister	o Sister
o Child	o Child	o Child	o Child

Diabetes?	Bleeding Problems?	Osteoporosis?	Other?
o None	o None	o None	
o Father	o Father	o Father	_____
o Mother	o Mother	o Mother	_____
o Mother's Father	o Mother's Father	o Mother's Father	_____
o Mother's Mother	o Mother's Mother	o Mother's Mother	_____
o Father's Father	o Father's Father	o Father's Father	_____
o Father's Mother	o Father's Mother	o Father's Mother	_____
o Brother	o Brother	o Brother	
o Sister	o Sister	o Sister	
o Child	o Child	o Child	