

Ortho Utah

Dr. Michael H. Sumko, DO
Dr. Matthew F. Bitner, MD
Dr. Daniel D. Higbee, DO

Patient name: _____

Date of Birth: _____

Who requested that you visit our office?

- Doctor (name) _____
- Self referral
- Other _____

Did you bring X-rays or other diagnostic imaging? ___Yes ___No

Have you had diagnostic imaging at another facility? (Name of facility) _____

Have you received any previous treatment for this problem?

If yes, please explain: (brace, medication, therapy, surgery, and injection)

Past Surgical History

List all surgeries (most recent first)

| Type | Year |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Have you ever had problems with anesthesia? ___Yes ___No

If yes, please explain: _____

List all allergies to medications/food/latex/tape/other: _____

Medical History

List all medications you are currently taking, or have recently taken. Include the dose and frequency (once a day, twice a day, etc.) Be sure to include aspirin, blood thinners, cortisone, over-the-counter drugs, and herbals.

| Medication | Dose | Frequency | Route | Prescribing Dr. |
|------------|------|-----------|-------|-----------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Have you ever had, or do you presently suffer from:

- | | |
|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney/Bladder Infections |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Blood Clots/Phlebitis | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Poor Dental Health/Infections |
| <input type="checkbox"/> Chemical Dependency/Alcoholism | <input type="checkbox"/> Psoriasis or Other Skin Problems |
| <input type="checkbox"/> Chronic Infections | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Depression or Anxiety | <input type="checkbox"/> Reaction to General /Local Anesthesia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures/Stroke |
| <input type="checkbox"/> Difficulty Voiding | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ulcer/GERD/Indigestion |
| <input type="checkbox"/> Heart Problems/Pacemaker | <input type="checkbox"/> Visual Loss or Glaucoma |
| <input type="checkbox"/> Hepatitis, Jaundice | |

Social History

Have you ever used tobacco in any form? ___Yes ___No

If yes, please complete the following:

| Type of tobacco | From | To | Amount per day |
|-----------------|------|----|----------------|
| | | | |
| | | | |

Do you consume alcoholic beverages? ___Yes ___No

If yes, please complete the following:

| Type of alcohol | How much | How often |
|-----------------|----------|-----------|
| | | |
| | | |

Any history of illicit drug use? ___Yes ___No

Are you retired? ___Yes ___No

What is or was your occupation_____

Marital History? ___Married ___Single ___Divorced ___Widowed

Family History

- Family history not known
- No family history of significant or pertinent health problems
- Heart Disease
- Bones, joints, and muscles
- Glands, hormones, diabetes
- Other family history of disease_____