**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:

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

**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_____