Patient Medical Profile

590 Wakara Way
Salt Lake City, UT 84108

Place Patient Sticker Here

Visit Information

Reason for visit: ______________________ Primary Care Physician: ______________________

How'd you hear about us?: ______________________

Type of pain: ☐ Ache ☐ Stabbing ☐ Throbbing ☐ Shooting ☐ Dull ☐ Click / Pop Date of Injury: ___/___/___

Severity: None 0 1 2 3 4 5 6 7 8 9 10 Intolerable Duration of pain: __________ Location of pain: __________

Pain Aggravated By:
- ☐ Standing ☐ Walking ☐ Lying
- ☐ Sleeping ☐ Working ☐ Stairs
- ☐ Sitting ☐ Driving

Treatments Attempted:
- ☐ Pain Medications ☐ Anti-Inflammatory ☐ Rest
- ☐ Wheelchair ☐ Physical Therapy ☐ Ice
- ☐ Surgery ☐ **NONE**

Current Health

Please list any health problems that you are currently diagnosed with.

- ☐ Seizures ☐ Lung Disease ☐ High Blood Pressure ☐ Thyroid Problems ☐ Pulmonary Embolism
- ☐ Liver Disease / Jaundice ☐ Heart Disease ☐ Cancer ☐ Stomach Ulcers ☐ DVT (Blood Clots)
- ☐ Osteo Arthritis / Gout ☐ Asthma ☐ Diabetes ☐ Kidney Disease ☐ Reumatoid Arthritis
- ☐ Chronic Headache ☐ Depression
- ☐ Infections: Please explain: ______________________ Height __________
- ☐ Other Illness: Please explain: ______________________ Weight __________

Females Only:

Date of Last Menstrual Period: ___/___/___ Currently Pregnant? ☐ Yes ☐ No ☐ Possibly

Surgical History

Please list any previous surgeries and approximate dates of surgery

Surgery:	Date:	Surgery:	Date:
______________	___/___/___	______________	___/___/___
______________	___/___/___	______________	___/___/___
______________	___/___/___	______________	___/___/___
______________	___/___/___	______________	___/___/___
______________	___/___/___	☐ **NONE**	

Known Allergies to Anesthesia: ☐ No ☐ Yes Describe: ______________________

Medications

Prefered pharamcy, name and location: ______________________Phone:______________

Please list any medications that you currently use, including over-the-counter medications, vitamins, herbs, and prescribed drugs.

Medication:	Dose:	Medication:	Dose:
______________	________	______________	________
______________	________	______________	________
______________	________	______________	________
______________	________	______________	________
______________	________	☐ **NONE**	

Allergies

Known Drug Allergies:

- ☐ **None Known** ☐ Iodine ☐ Diagnostic Dyes ☐ Morphine
- ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Ibuprophen
- ☐ Sulfa Drugs ☐ Acetaminophen ☐ Latex
- ☐ Other: ______________________

Family History

Problem: Does it run in your family? Please list family Member(s) who have had health issue and indicate maternal or paternal

Problem				Problem			
Diabetes	☐ Yes	☐ No	____	Arthritis	☐ Yes	☐ No	____
Heart Disease	☐ Yes	☐ No	____	Hip Problems	☐ Yes	☐ No	____
Asthma	☐ Yes	☐ No	____	Cancer	☐ Yes	☐ No	____
Blood Clots	☐ Yes	☐ No	____				

Social History

Occupation: Current: ____ ☐ Disabled Reason for Disability: ____

Past: ____ ☐ Retired ____

Do you live alone: ☐ Yes ☐ No With Whom: ____

Do you smoke? ☐ Yes ☐ No ____ Packs / Day Quit: ____ Months Ago ____ Years ago

Do you drink alcohol? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently

Any recreational drug use? ☐ Yes ☐ No Please List: ____

Review of Systems:

Please circle any that apply.

General	Weight Loss Chills	Weight Gain Fever	Fatigue Sweats	Decreased Appetite
Eyes	Blurred Vision Glaucoma	Pain Glasses	Sore Contacts	Vision Loss
Ear, Nose, Throat	Hearing Loss	Sore	Inflammation	Dentures
Cardiovascular	High Cholesterol Heart Attack	Chest Pain Aortic Aneurysm	Palpitations Leg Swelling	Heart Murmur Shortness of Breath
Respiratory	Sleep Apnea Emphysema	Tuberculosis Wheezing	Pneumonia Sputum	COPD Coughing
Gastrointestinal/ Urinary	Bladder Infections Blood in Urine	Burning Incontinence	Hemorrhoids	Kidney Stones
Musculoskeletal	Injury	Joint Pain	Muscle Pain	Swelling
Skin	Color Change Bruises	Rash	Cellulitis	Breast Problems
Neurologic	Dizziness Tingling	Faint Headaches	Numbness Bad Balance	Stroke Trouble with Memory
Hematologic / Lymph	Leukemia	Edema	Anemia	Bleeding Disorders
Immunological	HIV	AIDS	Hepatitis	Sexually Transmitted Diseases
Psychological	Depression Night Sweats	Anxiety Sleep Disturbances	Manic	Personality Disorders

Other: ____

MD Only: All other systems reviewed and found to be negative ☐ Signature

Misc. Information

Please list anymore information that may be important to your visit today.

____

____

Signatures

Patient Signature: ____ ___/___/___

Reviewed By Staff:

Clinical Staff: ____ ___/___/___

Reviewed By Staff:

Pre-Op Staff: ____ ___/___/___

D124