Salt Lake Orthopaedic Clinic
Initial Visit Form

Name: _____ Today's Date:_____ Date of Birth: _____

Age:_____ Height:_____ Weight: _____ Handedness (R/L): _____

Referring Physician: _____

Primary Care Physician: _____

Chief Complaint

Why are you seeing the doctor today?_____

How did this happen? _____

Duration of symptoms: _____ Character of pain (i.e. dull, sharp, etc.)_____

Pain rating, at worst (scale of 1-10, 10 is worst): _____

What makes your problem worse? _____

What makes your problem better? _____

List any treatment, test, or X-rays you have had for this problem: _____

_____

Other Current and Past Medical Problems:

_____

_____

_____

_____

_____

_____

_____

_____

Surgeries/Hospitalizations Year Reason

_____

_____

_____

_____

_____

Have you ever had general anesthesia? ____No ____Yes

Have any problems with anesthesia? ____No ____Yes Describe_____

Medication/Supplements:

Dose Times/Day Reason

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies to Medications:

_____

_____

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother		A D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Social History

Job/school:_____

____Single ____Married ____Divorced ____Separated ____Widowed

Children ____No ____Yes # _____

Do you live alone? ____No ____Yes

Exercise? ____Daily ____Weekly ____Monthly ____Rarely ____ Never

History of substance abuse? ____ No ____Yes What?_____

Smoke currently? ____No ____ Yes ____Packs per day for ____ years.

Quit smoking? ____This year ____1 year ____5 years ____10 years

Previously smoked_____ Packs per day for _____years.

Drink alcohol? ____Daily ____1-2 x/week ____1-2 x/month ____1-2 x/year ____ None at all

Review of Systems

Are you currently having or have you ever had any problems with:

Circle

- Have you ever had a blood clot? Yes No
- Has a member of your immediate family ever had a blood clot Yes No
- Has a member of your immediate family ever had a bleeding disorder? Yes No
- Have you had any infections (ie. abscess, cellulitis, infected joint, etc.)? Yes No
- Have you ever been diagnosed with an ulcer or had a bleed in your stomach or intestine? Yes No
- Have you ever had a stent placed in your heart Yes No

General or Constitutional

High blood pressure	Yes	No
Skin problems	Yes	No
Recent exposure to communicable diseases	Yes	No
Malignant hyperthermia with anesthesia	Yes	No
Pulmonary Embolism	Yes	No

Please describe all **Yes** responses

_____

_____

Eyes

Severe headaches	Yes	No
Double vision	Yes	No
Legally blind	Yes	No
Macular degeneration	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No

Please describe all **Yes** responses

_____

_____

ENT

Difficult to open mouth sufficient to interfere with anesthesia	Yes	No
Sinus infections	Yes	No
Balance problems	Yes	No
Hearing loss	Yes	No

Please describe all **Yes** responses

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_____

Respiratory

Tuberculosis	Yes	No
Sleep apnea	Yes	No
Chronic cough	Yes	No
Pneumonia	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
Emphysema	Yes	No
Abnormal chest X-ray	Yes	No

Please describe all **Yes** responses

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_____

Cardiovascular

History of rheumatic fever	Yes	No
Heart murmur	Yes	No
Chest pain	Yes	No
Heart attack	Yes	No
Irregular heartbeat	Yes	No
Ankle swelling	Yes	No
Valve replacement	Yes	No
Congestive heart failure	Yes	No

Please describe all **Yes** responses

_____

Genitourinary

Frequent urination at night	Yes	No
Urinary tract infection	Yes	No
Frequency	Yes	No
Pain/burning with urination	Yes	No
Kidney stones	Yes	No

Please describe all **Yes** responses

Gastrointestinal

Jaundice or hepatitis	Yes	No
Stomach ulcers	Yes	No
Hiatal hernia	Yes	No
Reflux	Yes	No
Heartburn	Yes	No
Blood in stools	Yes	No
Irritable bowel syndrome	Yes	No
Diverticulosis	Yes	No
History of bowel obstruction	Yes	No
Hemorrhoids	Yes	No

Please describe all **Yes** responses

Neurologic

History of polio	Yes	No
Stroke	Yes	No
Seizures	Yes	No
Neurologic problems	Yes	No
Mental Health/phobias including anxiety, depression, psychosis, confusion, memory loss	Yes	No

Multiple sclerosis	Yes	No

Please describe all **Yes** responses

_____

_____

Orthopedic

Back problems	Yes	No
Muscle disorders	Yes	No
Fibromyalgia	Yes	No
Fracture of neck or spine	Yes	No
Arthritis of joints	Yes	No
Rheumatoid arthritis	Yes	No
Gout	Yes	No
Pseudogout	Yes	No

Please describe all **Yes** responses

_____

_____

Endocrine

Hypoglycemia	Yes	No
Thyroid problems	Yes	No
Diabetes	Yes	No

Please describe all **Yes** responses

_____

_____

Hematologic/Immunologic

Hemophilia	Yes	No
Transfusion problems	Yes	No
Bleeding tendency	Yes	No
History of cancer	Yes	No
Anemia	Yes	No

Please describe all **Yes** responses

_____

_____

Other medical problems/comments:

_____

_____

Reviewed by: _____M.D. Date: _____