



ROSENBERG COOLEY METCALF  
THE ORTHOPEDIC CLINIC AT PARK CITY

HEALTH HISTORY

MRN \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Referring Physician \_\_\_\_\_ City/State of Referring Physician \_\_\_\_\_

In your own words, what is (are) your specific concern(s)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you sustain an injury?  No  Yes Date of Injury? \_\_\_\_\_

Was it work related?  No  Yes

If work related, what is your current work status? \_\_\_\_\_

If not work related, during what activity? \_\_\_\_\_

How many reinjuries? \_\_\_\_\_

PRESENT/PAST MEDICAL HISTORY (please check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart disease                     | <input type="checkbox"/> Prostate disease              | <input type="checkbox"/> Liver disease         |
| <input type="checkbox"/> Cervical spine disorder           | <input type="checkbox"/> Bowel disease                 | <input type="checkbox"/> Nerve impairment      |
| <input type="checkbox"/> Seizures                          | <input type="checkbox"/> Severe headaches              | <input type="checkbox"/> Severe headaches      |
| <input type="checkbox"/> Tuberculosis/TB                   | <input type="checkbox"/> Muscle disease                | <input type="checkbox"/> Mental health problem |
| <input type="checkbox"/> Depression                        | <input type="checkbox"/> Chronic skin disease          | <input type="checkbox"/> Sleep apnea           |
| <input type="checkbox"/> High blood pressure               | <input type="checkbox"/> High cholesterol              | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Hypoglycemia (low glucose)    | <input type="checkbox"/> Thyroid disease       |
| <input type="checkbox"/> Stomach disease                   | <input type="checkbox"/> Kidney disease                | <input type="checkbox"/> Bladder disease       |
| <input type="checkbox"/> Blood clots/DVT                   | <input type="checkbox"/> Pulmonary Embolism            | <input type="checkbox"/> Bleeding tendency     |
| <input type="checkbox"/> Lumbar spine disorder             | <input type="checkbox"/> Anemia or other blood disease |  |
| <input type="checkbox"/> Cancer – Type: _____ Dates: _____ |  |  |

Treatment: Chemotherapy Radiation Surgery All

Remission: Y N

HOSPITALIZATIONS OTHER THAN SURGERIES (last 10 years): **None**

Approximate Date	Purpose
_____	_____
_____	_____
_____	_____

ORTHOPEDIC/NEUROLOGIC SURGERIES, FRACTURES (last 10 years): **None**

JOINT REPLACEMENT Hip Knee Shoulder R L Both  
Dates: \_\_\_\_\_

ARTHROSCOPY Hip Knee Shoulder R L Both  
Dates: \_\_\_\_\_

SPINE SURGERY: Type \_\_\_\_\_  
Dates: \_\_\_\_\_

OTHER TYPES: \_\_\_\_\_  
Dates: \_\_\_\_\_

FRACTURES: Body Part \_\_\_\_\_  
Treatment \_\_\_\_\_  
Dates: \_\_\_\_\_

**OTHER PAST SURGERIES: None**

HEART BYPASS      HEART VALVE REPLACEMENT      GALL BLADDDER  
APPENDIX              ORGAN TRANSPLANT              COSMETIC

OTHER: \_\_\_\_\_  
DATES: \_\_\_\_\_

**CURRENT MEDICATIONS (includes non-prescription products): None**

Drug	Dose	Frequency	Drug	Dose	Frequency
1. _____			2. _____		
3. _____			4. _____		
5. _____			6. _____		

**ALLERGY TO MEDICATION: None**

If yes, which ones \_\_\_\_\_ Type of reaction \_\_\_\_\_

**PERTINENT FAMILY MEDICAL HISTORY** (cancer, heart disease, hypertension, etc):  
\_\_\_\_\_

**SPECIAL CONSIDERATIONS: None**

Legally blind                       Hearing impaired                       Need handicap facilities  
 Pregnant                               Attempting pregnancy               Adverse reaction to anesthesia  
 Tobacco use:                      Y N      Packs/day \_\_\_\_\_  
 Alcohol use:                        Y N      Drinks /week \_\_\_\_\_  
 Recreational Drug use:      Y N      Type: \_\_\_\_\_ Frequency \_\_\_\_\_

**ACTIVITY LEVEL: None**

Competitive athlete               Well-trained/frequent sports               Occasional sports

**What would you like your physician/team to accomplish today?**

Accurate diagnosis               Medication                       Surgery plan if necessary  
 Healthy exercise plan               Nutritional plan               Physical therapy plan  
 Alternative therapy plan (may include acupuncture, massage, manipulation)  
 Disability info                       Other \_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PARENT/GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_