COMPREHENSIVE ORTHOPEDICS SPORTS MEDICINE

New Patient History
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SPORTSMEDUTAH

Name:	**Gender**
Date of Birth (mm/dd/yyyy):	□ Male □ Female

Reason for your visit today (brief):	**Vitals (Office Use)**
	BP:
	HR:

Medications:	Dose:
1)	
2)	
3)	
4)	
5)	
6)	
□ Not currently using medications	

Medication Allergies:	
Medication	Reaction
1)	
2)	
3)	
□ No medication allergies	

Preferred Pharmacy (name, approximate address):

Review of Systems (circle all that apply):	
General:	Declining health, weight change, nausea, vomiting
Head:	Headaches, dizziness, vision/sinus/dental problems
CV:	Chest pain, palpitations, passing out, leg swelling
Respiratory:	Shortness of breath, wheezing, cough
GI:	Abdominal pain, constipation, diarrhea
Genitourinary:	Bladder changes, menstrual problems (females)
MSK:	Pain, swelling, stiffness, redness
Neuro:	Numbness, weakness
Psych:	Nervousness, anxiety, depression
Allergic:	Skin rash, trouble breathing
Heme/Lymph:	Anemia, enlarged lymph nodes, swelling
Endocrine:	Always thirsty, frequent urination, abnormal growth, heat/cold intolerance
Skin:	Rashes, itching, eczema

Medical History:	
Please list any current or previous medical problems. (Example: diabetes, high blood pressure, etc)	
□ None	Date of Diagnosis
1)	
2)	
3)	
4)	
5)	
Comments:	

Orthopedic History:	
Please list any current or previous orthopedic problems. (Example: broken arm, ACL tear, etc)	
□ None	Date of Injury:
1)	
2)	
3)	
4)	
5)	
Comments:	

Surgical History:	
Please list all surgeries you have had. (Example: ACL repair, cholecystectomy, tonsillectomy, etc)	
□ None	Date:
1)	
2)	
3)	
4)	
5)	
Comments:	

Family History:	
Please list significant family medical problems (Example: diabetes, cancer, etc)	
□ None	Date:
1)	
2)	
3)	
4)	
5)	
Comments:	

Social History:	
Sports or activities you enjoy:	
Occupation:	
Relationship Status:	□ married □ single □ divorced □ widowed □ other: _________
Children:	□ no □ yes. If yes, how many children do you have? __________
Do you currently smoke?	□ no □ yes. If yes, how many packs per day _____, years ______
Did you previously smoke?	□ no □ yes. If yes, how many packs per day _____, years ______
Do you drink alcohol?	□ no □ yes. If yes, how many drinks per day week? ___________
Do you use any illegal drugs?	
Comments:	

Referral Source
Please identify how you were referred to our clinic. Select the one that applies the most.
□ Friend, Relative, or Word of Mouth
□ Insurance
□ Internet Search. What search or what website? _________________
□ Previous patient of another doctor in this practice
□ Team affiliation. A doctor from our office provides medical care for your team. Team: __________
□ Physical therapy. Name of therapist or group: ________________________________
□ Physician. Name of physician or group: ________________________________
□ Self referred
□ Sports Med Utah advertising (banner, flier, website, event, radio, TV, etc)
□ Other:

Prior to this visit/referral…	**Yes**	**No**
Have you ever heard of Sports Med Utah?		
Have you ever heard of Comprehensive Orthopedics and Sports Medicine?		
Did you know there were medical clinics in the Jordan Commons Office Tower?		

Patient Signature (or parent/guardian): Date: