WEST IDAHO ORTHOPEDICS & SPORTS MEDICINE

PATIENT INFORMATION SHEET

Today's date: _____

Name: _____ DOB: _____

Who referred you to us? _____ Preferred Pharmacy: _____

Height _____ Weight _____

Reason for Visit: _____ When did symptoms begin? _____

Is this a result of an injury? □ No □ Yes If yes, check one: □ Work-related □ Auto Accident □ Sports Injury □ Other

Date of Injury: _____ Is there litigation pending: □ No □ Yes

Describe how accident occurred: _____

Is your condition affecting your activities of daily living? □ No □ Yes

Mark your current level of pain: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Do you use any of the following? □ Yes, Currently □ No, Never □ No, I am a former tobacco user Year Quit_____
Check all that apply: □ Cigarettes □ Cigars □ Pipe □ Smokeless-Tobacco □ Vape If yes how many per day? _____

Do you use alcohol? □ No □ Yes If yes, how many drinks per week? _____

Allergies / Intolerances			
□ Medication	□ X-Ray Dye	□ Latex	□ Other
□ Pollen	□ Food	□ Adhesives	□ None
□ Soaps/Lotions	□ Environment	□ Metals	
List substances & reaction:			

Current Medications (continue on back of page if needed)	**Dosage**

Previous Surgery (continue on back of page if needed)	**Date**

Have you ever had a surgical complication? □ Yes □ No Please Specify: _____

Have you ever had any of the following? Check all that apply: □ Joint Disease □ Stroke □ Thyroid □ Blood Clot □ Diabetes
□ High Blood Pressure □ Tuberculosis □ Cancer □ Heart Disease □ Other: _____

Do any of these conditions run in your family? Check all that apply:

Family Member	Diabetes	Lung Cancer	Breast Cancer	Heart Disease	Joint Disease	Stroke	Blood Clot	Psychiatric Disorders
Father								
Mother								
Sister								
Brother								
Other								

Signature: _____ Date: _____