

Pocatello Orthopaedics & Sports Medicine Institute
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PATIENT'S LEGAL NAME: _____ DATE: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PHONE: _____ AGE: _____ DATE OF BIRTH: _____ SEX: _____

SOCIAL SECURITY #: _____ MARRIED: _____ SINGLE: _____ DIVORCED: _____ WIDOWED: _____

OCCUPATION: _____ EMPLOYER: _____

BUSINESS PHONE: _____ EMPLOYER'S ADDRESS: _____

SPOUSE/NEAREST RELATIVE: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ PH # _____

OCCUPATION: _____ EMPLOYER: _____

PLEASE COMPLETE THE FOLLOWING IF PATIENT IS A MINOR:

RESPONSIBLE PARTY: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER'S TELEPHONE #: _____ SSN: _____

PRIMARY INSURANCE CO. _____ **ID#** _____

Group # _____ **Policyholder Name** _____ **Policyholder DOB** ___/___/___

If Medicaid Healthy Connections, Name of Primary Care Physician _____

SECONDARY INSURANCE CO. _____ **ID#** _____

Group # _____ **Policyholder Name** _____ **Policyholder DOB** ___/___/___

If Medicaid Healthy Connections, Name of Primary Care Physician _____

ALLERGIES: _____

MEDICATIONS PATIENT NOW TAKING: _____

PREVIOUS SURGERY: _____

PRESENT PROBLEM: _____

REFERRED BY: _____

OTHER MEDICAL PROBLEMS (I.E. DIABETES, HIGH BLOOD PRESSURE, HEART ATTACKS, BLEEDING TENDENCY, CLOTS IN LEG...) _____

YES NO

COMMENTS

- Muscle weakness _____
- Loss of bladder/bowel control _____
- Fevers _____
- Chills _____
- Weight loss greater than 10 lbs in one month _____
- History of cancer _____
- Night pain _____
- Rash _____
- Arthralgias _____
- Abdominal pain _____
- Morning stiffness _____
- History of rheumatic disease _____
- History of bleeding disorder _____
- Family history of bleeding disorder _____
- History of anesthetic complications _____
- Family history of anesthetic complications _____
- History of iritis or conjunctivitis _____
- Diabetes _____
- Headaches _____
- Dizziness _____
- Tremors _____
- Depression _____
- Change in hearing _____
- Cough _____
- Chest pain _____
- Swollen ankles _____
- Trouble swallowing _____
- Urinary stones _____

NAME _____

DATE _____