

Park City:
2200 Park Ave. Bldg D. Suite 100
Park City, Ut 84060

Old Mill Medical Center:
6360 So. 3000 East, Suite 210
Salt Lake City, UT 84121



HEIDEN ORTHOPEDICS

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Patient Health History/Subjective Information

Legal First Name _____ Legal Last Name _____ Middle Initial _____ Birth Date _____

Pharmacy Preference _____ Pharmacy Address _____ Fax Number _____

Reason for today's visit: _____

How long have you been experiencing these problems? _____ Current Weight _____ lbs. Current Height _____' _____"

Please List Any Medications You Are Currently Taking, Including Over-The-Counter Medications, Vitamins, etc.

Name of Medication	Dosage	How Often Taken	Are You Allergic to Any Medications?	
			Name of Medication	Type of Reaction
			Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list them below.	

List All Hospitalizations/Surgeries	Date

Have you ever had any problems with Anesthesia?
Yes No If yes, please list problems below

If you need additional space for Medications or Hospitalizations/Surgeries, please use the back of this form.

Treatments Attempted	No Relief	Good Relief	
Bed Rest			
Physical Therapy			
Chiropractic			
Home Exercise or Home Health Services			
Heat or Cold Therapy			
Wearing a Sling, Brace or Orthotics			
Spinal or Muscle Injections			
TENS Unit			

Personal Habits

Tobacco? Yes No
Packs per day _____
For how long _____
Quit date _____

Alcohol? Yes No
Drinks per day _____
Type (beer, Wine, Liquor, etc.) _____

Rate your pain by marking 0-10 on the scale below.
Zero (0) = No pain and Ten (10) = Extremely Intense Pain
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

General Medical History

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcers or GI Bleeding	<input type="checkbox"/> Pregnant
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Liver or Kidney Disease	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Weight Loss/Gain
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Depression	<input type="checkbox"/> Circulation Problems