Park City:
2200 Park Ave. Bldg D. Suite 100
Park City, UT 84060
Tooele:
2356 N 400 E, Bldg B, Suite 102
Tooele, UT 84074
Old Mill Medical Center:
6360 South 3000 East, Suite 210
Salt Lake City, UT 84121

HEIDEN ORTHOPEDICS

Eric Heiden, MD
Daniel Gibbs, MD
Karen Heiden, MD
Richard Zipnick, MD
Jason Dickerson, DPM
Enrique Feria-Arias, MD
Lindsey Marshall, PA-C
Whitney Schroder,PA-C

Patient Health History/Subjective Information

_______________ _______________ _______________ ____/____/____ ________
Legal First Name | Legal Last Name | Middle Initial | Birth Date | Age

____ ____-____-____
Pharmacy Preference | **Pharmacy Address** | **Fax Number**

Reason for today's visit: ______________________________ Dominant Hand: Left ☐ Right ☐

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.

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Name of Medication	Dosage	How Often Taken	Are You Allergic to Any Medications?	
			Yes ☐ No ☐ If yes, please list them below.	
			Name of Medication	**Type of Reaction**
USE SECOND PAGE IF NEEDED				

Hospitalizations, Surgeries or Serious Illnesses	Date

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

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

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

General Medical History				
☐ Heart Disease	☐ Cancer/Tumor	☐ Asthma	☐ Ulcers or GI Bleeding	☐ Pregnant
☐ High Blood Pressure	☐ Diabetes	☐ HIV/AIDS	☐ Liver *or* Kidney Disease	☐ Pacemaker
☐ Heart Murmur	☐ Arthritis	☐ Hepatitis	☐ Osteoporosis	☐ Epilepsy
☐ Fibromyalgia	☐ Scoliosis	☐ Emphysema	☐ Thyroid Disorder	☐ Weight Loss/Gain
☐ Bleeding Disorder	☐ Tuberculosis	☐ Stroke	☐ Depression	☐ Circulation Problems

Review of Systems: Check all that apply				
HEENT:	GI:	CV:	EXTREMITIES/MUSCULOSKELETAL:	HEMATOLOGY
☐ Difficulty Seeing	☐ Vomiting	☐ Irregular heartbeat	☐ Stiffness	☐ Anemia
☐ Eye Pain	☐ Diarrhea	☐ Heart murmur	☐ Back Pain	☐ Blood clot
☐ Change in Vision	☐ Bloody Stools	☐ Chest Pain on Exertion	☐ Diminished range of motion	☐ Easy Bruising
☐ Ringing in Ears	☐ Dark/tarry stools	RESPIRATORY:	☐ Swelling	☐ Easy Bleeding
☐ Hearing Loss	☐ Nausea	☐ Cough	☐ Pain	NEUROLOGY:
☐ Sore throat	ENDOCRINE:	☐ Pain with breathing	GU:	☐ Headache
☐ Runny nose	☐ Intolerant to Heat	☐ Wheezing	☐ Painful Urination	☐ Migraines
☐ Sinus Problems	☐ Intolerant to Cold	☐ Shortness of breath	☐ Bloody Urine	☐ Seizures
PSYCH	☐ Osteoporosis	SKIN:	☐ Urinate Frequently	☐ Stroke
☐ Depression	☐ Osteopenia	☐ Rash	☐ Awake at Night to Urinate	☐ Dizziness
☐ Anxiety	☐ Excessive Thirst	☐ Legions	NECK:	☐ Numbness
☐ Fatigue	☐ Excessive Hunger	☐ Lumps	☐ Neck or Thyroid Enlargement	☐ Weakness
☐ Drug Addiction	☐ Unusual Weight Gain	☐ Sores	☐ Other	☐ Other
☐ Alcohol Addiction	☐ Unusual Weight Loss	☐ Psoriasis	☐ Other	☐ Other

Social History	
Do you Use Tobacco? Yes ☐ No ☐ Packs per day ___________________________________ For how long ___________________________________ Quit date _______________________________________	Drink Alcohol? Yes ☐ No ☐ How many drinks per day ________________________________ How many drinks per week _____________________________ Type (beer, Wine, Liquor, etc.) ___________________________ Quit date____

ADDITIONAL MEDICATIONS:

Name of Medication	Dosage	How Often Taken

Signature ____Date ____________________