Park City:
2200 Park Ave. Bldg D. Suite 100
Park City, UT 84060
Tooele:
2326 N 400 E, Bldg C, 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 Schroeder,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 BACK OF PAGE IF NEEDED				

Hospitalizations	Date

Surgeries	Date

Rate your pain by marking 0-10 on the scale below.

Zero (0) = No pain. 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

Family Medical History						
☐ Father	☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Mental Disorder	☐ Cancer	☐ Other
☐ Mother	☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Mental Disorder	☐ Cancer	☐ Other
☐ Sibling	☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Mental Disorder	☐ Cancer	☐ Other
☐ Children	☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Mental Disorder	☐ Cancer	☐ Other
☐ Grandparent	☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Mental Disorder	☐ Cancer	☐ Other

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

Serious Illness not listed above? Yes ☐ No ☐
Illness type _____
For how long _____

Are you currently pregnant or breastfeeding?
Breastfeeding? Yes ☐ No ☐
Pregnant? Yes ☐ No ☐
How far along? _____

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	☐ Lesions	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	
Tobacco Use? Yes ☐ No ☐	Alcohol Use? Yes ☐ No ☐
Packs per day _____ For how long _____	How many drinks per day _____ For how long _____
Type (cigarettes, vaping, chew, etc.) _____	Type (beer, wine, liquor, etc.) _____
Quit date _____	Quit date_____

Recreational Drug Use? Yes ☐ No ☐
Frequency _____ For how long _____
Type _____
Quit date _____

Recreational Activities or Hobbies (Please list)

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			
Topical Creams (CBD, THC, etc.)			

Signature _____ **Date** _____