CASEY I. HUNTSMAN, M.D. – HUNTSMAN ORTHOPAEDIC SURGERY AND SPORTS MEDICINE PA
JASON G. DALLING, M.D. – DALLCO ORTHOPAEDICS & SPORTS MEDICINE, PLLC
BRANDON MENNEAR, M.D. – MENNEAR ORTHOPEDICS, LLC

3300 Washington Parkway Phone: 208-522-6662 Fax: 208-522-0880
Idaho Falls, ID 83404

MEDICAL HISTORY FORM

Date _____ Referring Doctor _____

Name (print) _____ Age _____ Birthdate _____

1. What are you being seen for today? _____
2. When did the accident occur or the symptoms start? _____
3. If it was an injury, where and how did it happen? _____
   _____
4. Is this a workers' comp claim? _____
5. Is there any history of this or a similar problem prior to the current condition? _____
   _____
6. Who is your primary care physician? _____
7. Which pharmacy do you use? _____
8. Please list any medications you are now taking, prescription and over the counter.

Name of medication	Dosage (example 10 mg)	How often

Allergies (include all drug allergies and describe reaction) _____
_____

9. Do you drink alcohol? ☐ No ☐ Yes How many drinks per week? _____
   Do you smoke or chew tobacco? ☐ No ☐ Yes How many per day? _____ How long? _____
10. Are you ☐ Right handed or ☐ Left Handed?

Please continue on reverse side of this form.

11. Height _____ Weight _____ Occupation _____

12. Do you get regular exercise? ☐ No ☐ Yes (What type and how often?) _____

_____

13. List any fractures or other serious injuries with date and type: _____

_____

_____

14. List operations and dates:

_____

_____

_____

_____

15. Orthopedic History – Please check any of the following conditions you have had or now have.

☐ Arthritis	☐ Torn cartilage	☐ Sprained joints	☐ Neck or back pain
☐ Gout	☐ Joint infection	☐ Dislocated joints	☐ Tendinitis
☐ Osteopenia	☐ Osteoporosis	☐ Bursitis	☐ Stiff joints
☐ Torn muscles or tendons	☐ Problems you were born with	☐ Rheumatoid arthritis ☐ Joint pain	☐ Use cane / walker

16. Past Medical History – Please check any of the following conditions you have had or now have.

☐ High blood pressure	☐ Heart problems	☐ Bleeding problems	☐ Kidney problems
☐ Hiatal hernia	☐ Bladder problems	☐ Urinary infections	☐ Stroke
☐ Colitis or Crohns	☐ Ulcers	☐ Seizures	☐ Asthma
☐ Emphysema	☐ Diabetes	☐ Pneumonia	☐ Staph infections
☐ Thyroid problems	☐ HIV / AIDS	☐ Hepatitis	☐ Cancer
☐ Skin problems	☐ Gallbladder problems	☐ Psychiatric problems	☐ Loss of sensation
☐ Trouble hearing	☐ Corrective eyewear	☐ Trouble swallowing	☐ Depression
☐ Severe headaches	☐ Weakness	☐ Blood clots	☐ Sleep apnea

17. Please describe any of the problems you have checked on the lists above or are not listed. _____

_____

_____

_____

_____

18. Family History – immediate family: mother, father, brothers, sisters, grandparents:

☐ Arthritis	☐ Heart problems	☐ Diabetes	☐ Cancer

☐ Other: _____

_____

Thank You