

Please list any allergies:

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Past family history – Please check all the following medical problems anyone of your immediate family (mother, father, brother, sister, grandparents) has had:

- Arthritis
- Diabetes
- Heart Problems
- Anesthesia Problems
- Bleeding Problems
- Blood Clot
- Foot Problems

**Review of Systems – Please check any of the following you have had recently:**

- Chest Pain
- Cough
- Shortness of breath
- Extremity Weakness
- Frequent Rashes
- Joint Pain
- Muscle Pain
- Trouble walking, use of cane/walker
- Extremity Swelling
- Bruise easily
- Numbness/Tingling
- Excessive Thirst
- Excessive Urination
- Burning with urination
- Difficulty swallowing
- Stomach Pain/Burning
- Fainting Spells
- Frequent constipation
- Difficulty Sleeping
- Troubled by depression
- Troubled by Anxiety
- Tired/Sluggish
- Severe Headaches
- Have you considered suicide?

**Past Medical History – Please check any of the following you have ever had:**

- High Blood Pressure
- Heart problems
- Bleeding problems
- Blood clot phlebitis
- Irregular Heartbeat
- Varicose Veins
- Stroke
- Pneumonia
- Tuberculosis
- Asthma
- Emphysema
- Mitral Valve Prolapse
- Diabetes
- Psoriasis
- Gout
- Rheumatoid Arthritis
- Kidney Failure
- Urinary Infections
- Colitis
- Gallbladder problems
- Ulcers
- Hiatal Hernia
- Seizures
- Cancer
- HIV/Aids
- Thyroid problems
- Other Infections
- Psychiatric Problems

Please describe any problems you have checked from the list above:

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Please list any past surgeries (and year):

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# CALTON-HARRISON CLINIC

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## PATIENT QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

Describe what brings you here today: \_\_\_\_\_

Where does it hurt? \_\_\_\_\_

How long have you had the problem? \_\_\_\_\_

What makes it better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Please describe the type of pain you have (circle all that apply):

Sharp      Aching      Stabbing

Dull      Cramping      Throbbing

Pins &      Constant      Comes &  
needles           goes

If it is an injury, when did it happen? \_\_\_\_\_

How did it happen? \_\_\_\_\_

On a scale of 1 – 10, how severe is the pain?

Where does it occur?

no pain    1 2 3 4 5 6 7 8 9 10    severe pain    Home    School    Work    Auto    Other \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

Do you see any other specialists? \_\_\_\_\_

Which pharmacy do you use? \_\_\_\_\_ Phone \_\_\_\_\_

**Please list any medications you are now taking, prescription and over the counter.**

Name of Medication	Dosage (example 10 mg)	How often do you take it?

### MEDICAL HISTORY

Do you get regular exercise?    NO    YES    What type and how often? \_\_\_\_\_

Do you drink alcohol?    NO    YES    How many drinks per week? \_\_\_\_\_

Do you smoke?    NO    YES    How many per day? \_\_\_\_\_ How long? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

How many years of school? \_\_\_\_\_

Your height \_\_\_\_\_ Your weight \_\_\_\_\_