3381 West Bavaria Street, Eagle, ID 83616 ● Phone (208) 639-4800 ● Fax (208)639-4801 ● humphrey@boiseshoulderclinic.net

C. SCOTT HUMPHREY, MD Orthopaedic Surgeon

Patient Name				
Date of Birth		_		
		Primary Care MD		
		Divorced		
Name of Spouse/Signif	icant other			
Dominate hand	_RightLeft			
Chief complaint				
Ciliei Collipialiit				
Are you currently invol	ved in a lawsuit regardi	ng your injury? If so, who	is your representativ	/e? 
Drug allergies		Reaction	Last occu	
4				
		If so, what kind?		
Current medications		Dosage	Frequer	ncv
	ne-counter medications	such as multi-vitamins, as	•	icy
			•	
· 5				
 6				
7				
Prior surgeries	Side (if applies	) Surgeon	/Place	Date
1				
2				
3				
4				
5				

-			•	•	Sports injury Auto accident Other		
Where did you s					Sports injury Auto decident Other		
•		• •			wHipKneeLegAnkleFoot		
					elow with the dates:		
ii you nave nau i	munupi	ie traum	a s, piea	ise expiain b	elow with the dates.		
Work History							
Occupation							
Full time	Pa	art-time	F	Retired	Disabled		
Education							
High School		_Trade S	chool	College	eMastersDoctorate		
Exercise Habits (	Please	mark ho	ow many	days a wee	k you participate in activity, i.e4Walking2_Running)		
Walking	F	Running		Hiking _	ClimbingSwimmingCycling		
Golfing	s	oftball	P	ilates	Weight-liftingBasketballAerobics		
Other activity							
Social History							
Tobacco							
Never	Pr	eviously	, but qui	tCu	rrentPacks/cans, per day		
Alcohol							
No	Rare	·	_Social	Daily	(How many drinks per day)?		
Illicit Drug Use							
Never _	Ye	es Ty	pe/Freq	uency			
Have any of you	r imme	ediate fai	mily bee	n diagnosed	and/or treated for the following?		
If yes, please list	below	in their	Medical	History.			
Arthritis	H	leart Dis	ease _	Cancer	High Blood PressureDiabetes/Type I		
Diabetes Ty	pe II						
Family History							
Family							
Member	Age	Name	Living	Deceased	Medical History		
Father							
Mother							
M or F							
M or F							
M or F							
M or F							
M or F							
M or F							
M or F							

Have you ever been treated for	Congestive heart failure		
the following?			
Polio	Respiratory:	Vascular:	
Meningitis	Asthma	Deep Vein Thrombosis	
Pericarditis	Chronic Bronchitis	Claudication	
Pancreatitis	Cough		
Endocarditis	Shortness of breath	Skin:	
Pneumonia	Tuberculosis	Psoriasis	
Hepatitis A		Rashes	
Hepatitis B	GI:	Lesions	
Hepatitis C	Gastric Reflux	Hives	
	Peptic Ulcer Disease	<del></del>	
If marked yes to the above,	Vomiting	Lymphatic:	
please include the date and how	Bowel incontinence	Lymphadenopathy	
long you were treated.	Peptic ulcer disease	Lymphadenitis	
· ·	<u> </u>	Breast cancer	
	GU:	Prostate cancer	
	Urinary frequency		
Constitutional:	Urinary hesitancy	Psychiatric:	
Pain interfering with sleep	Urgency	Chronic insomnia	
Cancer (specify type in space	Urinary Hematuria	Depression	
below)	Benign Prostate Hypertrophy	Anxiety	
Chills or Fever	benign rostate hypertrophy	Schizophrenia	
Complications from anesthesia	Musculoskeletal:	5611120 p1111611114	
Recent weight loss	Previous surgery	Other:	
Necent weight loss	Joint pain	Other.	
Neurologic:	Joint stiffness		
Dizziness	<del></del>	If you are currently being treated	
	Muscle pain	If you are currently being treated for any other medical condition o	
Migraines	Osteoarthritis	need to elaborate on a condition	
Seizures	Rheumatoid arthritis		
Multiple sclerosis	Osteopenia	marked above, please explain in	
-	Osteoporosis	the space below.	
Eyes:	Bone cancer		
Recent vision changes			
Blurry vision	Endocrine:		
	Diabetes – Type I		
ENT:	Diabetes – Type II		
Difficulty swallowing	Thyroid disease		
Sinus disease	Kidney disease		
Hearing loss			
	Immunologic:		
Cardiac:	Lupus		
Hypertension	Fibromyalgia		
Angina	Steroid therapy		
Myocardio Infarction			
Arrhythmia			