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1441 Parkway Drive
Blackfoot, Idaho 83221
Phone: (208) 785 1044

ROBERT J. LEE, M.D.
BOARD CERTIFIED ORTHOPAEDIC SURGEON

Personal Information			
Last Name:	First Name:	Middle Name:	
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:		
Email Address:	May we contact you via email? ☐ Yes ☐ No		
Emergency Contact	Gender: ☐ Male ☐ Female	Date of Birth (MM/DD/YYYY):	Age:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Race:	Ethnicity:	SSN:
Occupation:	Employer:	Employer Address:	
Is Patient a child? ☐ Yes ☐ No	Father's Name:		
	Mother's Name:		

How did you find us?	
☐ By Referring Physician:	☐ Online – which site?
☐ By Another Patient:	☐ Other:
Who is your Primary Physician:	
Has any family member been seen in this office? ☐ Yes ☐ No	Family member name:

History of present injury		
Reason for visit:		
Date of injury:	Hand dominance: ☐ Right ☐ Left	
Did this injury occur at work? ☐ Yes ☐ No	Did this injury occur from an auto accident? ☐ Yes ☐ No	
Was this body part previously injured? ☐ Yes ☐ No	If so, how?	
How and where did the injury occur?		
Whom have you previously seen for this condition?		
What studies have been performed for this condition? (MRI, CT, X-ray, EMG, etc.):		

Insurance Information (if patient is a minor, parent information is required)		
Primary Insurance:	Subscriber:	
Subscriber Date of Birth:	Subscriber SSN:	
Group #:	ID #:	Plan #
Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (explain):		
Secondary Insurance:	Subscriber:	
Subscriber Date of Birth:	Subscriber SSN:	
Subscriber Employer:	Employer Phone:	
Group #:	ID #:	Plan #
Relationship of Patient to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (explain):		

I hereby authorize my insurance benefits to be paid directly to *Robert J. Lee, M.D., PC*. I understand I am financially responsible for non-covered services and balances remaining after insurance pay. I authorize *Robert J. Lee, M.D., PC* to release any information required to process this claim.

Patient or Guarantor Signature

Date

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Current Health			
Height:	Weight:	Pregnant or could be pregnant ☐ Yes ☐ No	
Medical conditions that I have		☐ No medical conditions that I know of	
☐ High blood pressure	☐ Stomach ulcers/gastritis	☐ Thyroid problems	☐ Osteoarthritis
☐ High cholesterol	☐ Stomach reflux/GERD	☐ Kidney problems	☐ Rheumatoid arthritis
☐ Heart problems	☐ Anesthesia reactions	☐ Prostate problems/BPH	☐ Osteoporosis/brittle bones
☐ Heart attack	☐ MRSA	☐ Liver problems/hepatitis	☐ Stroke/CVA
☐ Diabetes	☐ Emphysema/COPD	☐ HIV/AIDS	☐ Neuropathy
☐ Blood clot formation/DVT	☐ Pulmonary embolus	☐ Cancer	☐ Depression
☐ Blood flow problems/PVD	☐ Pneumonia	☐ Sleep Apnea	☐ Alzheimer's
Other medical problems I have/more info:			

Operations I have undergone in the past		☐ I have had no major operations in the past
☐ Appendectomy	☐ Heart surgery	☐ Shoulder surgery
☐ Tonsillectomy	☐ Cardiac catheterization	☐ Knee surgery
☐ Cholecystecomy	☐ Cardiac stent placement	☐ Previous bone or joint surgery
☐ C-Section	☐ Colonoscopy/endoscopy	
Other surgeries I have undergone/more info:		

Medications I am currently taking		☐ I am currently taking no medications regularly	
Medication	Dosage (mg)	How Often	I take it for my:

Allergies I have to medications	☐ I have no known allergies to any medications
Medication	**Type of reaction (rash, nausea, stopped breathing, etc.)**
Allergies I have to anesthesia	☐ I have no known allergies to anesthesia
If yes, describe:	

Family Medical History		☐ No medical problems in my family that I know of	
Medical problem:	**In my (mother, father, etc.):**	**Medical problem:**	**In my (mother, father, etc.):**
☐ High blood pressure		☐ Osteoarthritis	
☐ High cholesterol		☐ Rheumatoid arthritis	
☐ Heart problems		☐ Other joint problems	
☐ Diabetes		☐ Osteoporosis/brittle bones	
☐ Asthma		☐ Neuropathy	
☐ Blood clot formation/DVT		☐ Alzheimer's	
☐Bleeding problems		☐ Cancer	
☐ Anesthesia problems		☐ Other:	
☐ Stroke/CVA		☐ Other:	

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I am active in			
☐ No specific sport or exercise	☐ Cycling	☐ Basketball	☐ Gymnastics
☐ Walking for fitness	☐ Mountain biking	☐ Golf	☐ Skiing
☐ Exercising at the gym	☐ Hiking	☐ Tennis	☐ Snowboarding
☐ Weight training	☐ Baseball/Softball	☐ Volleyball	☐ Dance/cheer
☐ Running	☐ Soccer	☐ Lacrosse	☐ Other:
☐ Swimming	☐ Football	☐ Hockey	

Alcohol Use	**Tobacco Use**	**Recreational Drug Use**
☐ None/Rarely	☐ I don't smoke	☐ None
☐ 1-2 drinks/week	☐ I quit in _____ after smoking _____packs/day for _____ years	☐ Occasionally
☐ 1-2 drinks/day	☐ ½ to 1 pack/day	☐ Regularly
☐ Three or more drinks/day	☐ 2 or more packs/day	☐ Drugs I commonly use:
☐ Difficulty with heavy alcohol use in the past		

Review of symptoms – These are symptoms I commonly experience (check only if yes)

- o Chills
- o Fatigue
- o Fever
- o Unintentional weight gain
- o Unintentional weight loss

- o Blurred vision
- o Glasses/contacts

- o Hearing loss
- o Nasal Congestion
- o Bloody Nose
- o Snoring

- o Chest pain
- o Dizziness
- o Palpitations
- o Pedal Edema
- o Tachycardia (racing heart)
- o Varicose veins

- o Acute cough
- o Chronic cough
- o Difficulty breathing
- o wheezing

- o Abdominal pain
- o Acid reflux
- o Difficulty swallowing
- o Constipation
- o Diarrhea
- o Heartburn
- o Nausea
- o Vomiting

- o Joint pain
- o Back pain
- o Joint stiffness
- o Limb pain
- o Muscle pain

- o Acne
- o Dry skin
- o Rashes

- o "Clumsy"
- o Dizziness
- o Fainting
- o Headaches
- o Memory loss
- o Numbness/Tingling
- o Tremor
- o Weakness

- o Easy bruising
- o Excessive bleeding

- o Hair loss
- o Heat/Cold intolerance

- o Seasonal allergies

- o Anxiety
- o Depression
- o Feeling Stressed
- o Loss of interest
- o Recreational drug use
- o Sadness
- o Suicidal thoughts

OTHER:

- o _____
- o _____
- o _____
- o _____
- o _____
- o _____

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Our Commitment to Quality Medical Care

Robert J. Lee, M.D., PC is committed to providing you with high quality medical care. We participate in continuing medical education to keep our knowledge and skills current and strive to ensure that our patients receive high quality medical care from this practice.

We also understand that as a patient, you may at times have concerns or complaints about our services. We encourage you to communicate your concerns to us or our staff. **Please tell us if you have a complaint or a complement – we value your feedback.**

Please tell us if you have questions about your care, suggestions to improve the delivery of health care in this office, or complaints about any aspect of your treatment. We appreciate being part of your health care team and ***greatly*** value your feedback. If you would prefer that your comment be anonymous, please find a comment box in our waiting room.