ORTHOPAEDIC ASSOCIATES
of Wisconsin
There is a Difference.

Medical History Form

Name: _____ Today's Date: _____

Date of Birth:_____ Age:_____

Occupation: _____ Dominant Hand □ R or □ L Height: _____ Weight: _____

Primary Care Physician (PCP):_____

Did a Physician refer you? □ No □ Yes, who?

_____

Chief Complaint: (Why are you here today? For example: "Left knee pain")

_____

Did the problem result from a specific injury? □ No □ Yes, Date of injury: _____

Is this a work related injury? □ No □ Yes, Date of injury: _____

Length of time with employer? _____ Has the injury been reported? □ No □ Yes

Can you describe the injury? If no injury, how did the problem start?

_____

_____

Symptoms: What symptoms are you experiencing? (Please check all that apply)

□ Pain □ Weakness □ Swelling □ Stiffness/Motion loss
□ Instability □ Locking □ Grinding □ Numbness/Tingling
□ Clicking □ Catching
□ Other _____

Quality: Describe the symptoms

□ Sharp □ Dull □ Stabbing □ Throbbing
□ Burning □ Achy □ Shooting □ Radiating

Duration: How long have you had symptoms? _____

Location: Where are your symptoms, specifically? _____

Timing: How often do you have symptoms? □ Occasional □ Frequent □ Constant
When do symptoms occur? □ With activity □ Morning □ Night

Severity: (rate 0=none, 10=severe, please circle)

At worst 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

At best 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you had any prior injuries to the area? □ No □ Yes: _____

Previous Treatment: Have you had any treatment for this problem?

□ No □ Physical Therapy □ Splinting/Bracing □ Medications:
□ Injections □ Chiropractor □ Surgery:

Did any of these treatments provide relief? □ No □ Yes, which ones and how much relief?

Please complete page 2 on opposite side.

Medical History:
Are you pregnant? □ Yes □ No □ Possibly
(Please check previous or current medical conditions)

□ None	□ Anemia	□ Gout	□ Metal Allergy
	□ Arthritis	□ Heart Disease/CAD	□ Osteoporosis
	□ Asthma	□ Hepatitis	□ Prostate
	□ Blood Clots/DVT	□ High Blood Pressure	□ Psoriasis
	□ Cancer	□ High Cholesterol	□ Stomach Ulcer/Reflux
	□ COPD/Lung Disease	□ HIV	□ Stroke/Seizures
	□ Depression	□ Irregular Heartbeat	□ Thyroid Disease
	□ Diabetes	□ Liver Disease	□ Vascular Disease

□ Other: _____

Have you ever had or been treated for MRSA (Methicillin-resistant Staphylococcus Aureus)/STAPH Infection? □ No □ Yes If Yes, Date Cleared: _____

Surgical History: (Please list previous surgeries/operations and dates)
□ None _____ _____ _____
_____ _____ _____

Osteoporosis: Have you undergone a bone scan or DEXA scan within the past 2 years?
□ No □ Yes
if yes, findings _____

Current Medications: (Please list names of all drugs and the doses you are taking)
□ None _____ _____ _____
_____ _____ _____

Allergies to Medications
□ None □ Yes, which drug? _____
What reaction? _____

Social History:
Marital Status: □ Single □ Married □ Divorced □ Widowed

Occupation: _____ Hobbies: _____

Do you smoke? □ No □ Yes _____packs/day for _____ years
Do you drink alcohol? □ No □ Rare □ Social □ Daily

Family History of Medical Conditions: (Please list any medical problems that run in your family)
□ None _____

Review of Systems: Are you ***currently*** experiencing any of the following symptoms? (Please check all that apply)

No	Yes					
□	□	**General**:	□ Fatigue	□ Weight gain/loss	□ Fever/Chills	□ Insomnia
□	□	**HEENT:**	□ Vision change	□ Hearing loss	□ Sinus pain	□ Sore throat
□	□	**Cardiovascular**	□ Chest pain	□ Palpitations	□ Edema	□ Poor circulation
□	□	**Respiratory**	□ Cough	□ Short of breath	□ Wheezing	□ Pneumonia
□	□	**Gastrointestinal**	□ Nausea/vomiting	□ Indigestion	□ Acid reflux	□ Stomach pain
□	□	**Genitourinary**:	□ Frequent urination	□ Difficult to urinate	□ Painful to urinate	□ Bloody urine
□	□	**Skin**	□ Rash	□ Hives	□ Sensitive skin	□ Easy scarring
□	□	**Neurological**	□ Headache	□ Dizziness	□ Seizures	□ Tremor
□	□	**Psychiatric**	□ Depression	□ Anxiety	□ Mood swings	□ Stress
□	□	**Endocrine**	□ Hypoglycemia	□ Diabetes	□ Thyroid	□ Hot Flashes
□	□	**Hematological**	□ Easy bruising	□ Easy bleeding	□ Anemia	□ Blood clots
□	□	**Immunologic**	□ Seasonal allergies	□ Food Allergies	□ Frequent infection	□ HIV

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____