



Aspen Orthopaedic and Rehabilitation Specialists, S.C.

Current Medical Data Form

PATIENT NAME: _____

Date problem started: _____ Body parts involved: _____

Symptoms: _____

Describe how problem started & its course: _____

Doctor or person who referred you for this Problem:			
Have you been treated for this problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, by whom?	
Are you off work for this problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Last Worked?	
Is this an athletic injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this auto accident related?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this a work related injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Were you injured at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this a personal injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, who is responsible?			
Is an attorney involved? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name of attorney:			

Other Bone Joint Muscle Problems: Bone or Joint Infection Osteoporosis Osteoarthritis Gout
 Bursitis Rheumatoid Arthritis Fractures Joint replacement surgery Other _____

List all prescription **DRUGS**, over the counter medicines, herbal remedies, inhalers, birth control pills, diet pills, blood thinners (Coumadin, Warfarin, Lovenox, Plavix, Aspirin, etc.) you are currently taking.

NAME OF MEDICATION(S)	DOSAGE	WHEN TAKEN - FREQUENCY

ALLERGIES to any drugs, medications, **LATEX**, nickel, etc? Yes No If yes, list medication & reaction below.

LIST MEDICATION	LIST REACTION(s)	KEY TO REACTION TYPE
		Hives , skin rash, itching, Shock , Unconsciousness , Asthma , shortness of breath, stomach ache, nausea, vomiting, diarrhea, constipation, anemia , blood disorder , bleeding , bone pain, muscle pain, weakness, numbness, tingling, fever, headaches,

TESTS you have had done for this problem: x-rays, MRI's, CT scans, Bone Scans, Blood Tests, EMG's, EKG's...

NAME OF TEST	BODY PART TESTED	DATE OF TEST	WHERE WAS TEST DONE?

List any past surgeries you have had:

NAME OF SURGERY	DATE OF SURGERY	HOSPITAL WHERE DONE

Marital status: Single Married Widow(er) Divorced

Occupation: _____ **How many years?** _____

Do you smoke? Yes No **How many packs daily?** _____ **How many years?** _____ **When stopped?** _____

Do you drink alcohol? Yes No less than 1 drink daily 1-2 drinks daily 3 or more daily

Diet Type: Regular Diabetic Low Salt Low Fat Other (explain?) _____

Do you drink caffeine? Yes No less than 1 drink daily 1-2 drinks daily 3 or more daily

Exercise? Yes No **If yes, what kind and frequency?** _____

When & where last Bone Densitometry scan (DEXA) done? _____ Never done

Check boxes below for those conditions which you have. If more space is needed, check box and use the back of this page.

<p>GENERAL:</p> <p>Recent weight <input type="checkbox"/> Gain or <input type="checkbox"/> Loss</p> <p><input type="checkbox"/> Fever, sweats, chills</p> <p><input type="checkbox"/> Fatigue, malaise</p> <p><input type="checkbox"/> MRSA infection now or in past</p> <p>HEENT SYSTEMS:</p> <p><input type="checkbox"/> Blind 369.4</p> <p><input type="checkbox"/> Cataract 366.9</p> <p><input type="checkbox"/> Recent changes in vision</p> <p><input type="checkbox"/> Glaucoma 365.9</p> <p><input type="checkbox"/> Hearing problem</p> <p><input type="checkbox"/> Hearing Loss 389.9</p> <p><input type="checkbox"/> Meniere's Disease 386.00</p> <p><input type="checkbox"/> Pain or ringing in ears</p> <p><input type="checkbox"/> Nose or sinus problem</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Throat irritation</p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Infected teeth</p> <p><input type="checkbox"/> Neck swelling or lumps</p> <p><input type="checkbox"/> Chronic Sinusitis 473.9</p> <p>HEART & CIRCULATORY:</p> <p><input type="checkbox"/> Blocked blood vessels</p> <p><input type="checkbox"/> Cardiomyopathy 425.4</p> <p><input type="checkbox"/> Chest pain or tightness</p> <p><input type="checkbox"/> Coronary artery disease</p> <p><input type="checkbox"/> Irregular heart beat 427.9</p> <p><input type="checkbox"/> High blood pressure 401.9</p> <p><input type="checkbox"/> High Cholesterol or triglycerides 272.4</p> <p><input type="checkbox"/> Mitral valve prolapsed 424.0</p> <p><input type="checkbox"/> Myocardial Infarction 410.90</p> <p><input type="checkbox"/> Pacemaker or defibrillator V45.01</p> <p><input type="checkbox"/> Shortness of breath with lying down, exertion, or at night</p> <p><input type="checkbox"/> Stroke. 434.90</p> <p><input type="checkbox"/> Swelling in both legs</p> <p><input type="checkbox"/> Leaky Heart Valve 746.9</p> <p><input type="checkbox"/> Heart surgery (describe on page 1)</p> <p><input type="checkbox"/> Cardiologist _____</p> <p>BREASTS:</p> <p><input type="checkbox"/> Pain, lumps, discharge</p> <p>Last mammogram _____</p>	<p>LUNGS & RESPIRATORY:</p> <p><input type="checkbox"/> Asthma 493.90</p> <p><input type="checkbox"/> Bronchitis 491.20</p> <p><input type="checkbox"/> COPD 493.20</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Emphysema 492.8</p> <p><input type="checkbox"/> Pulmonary embolism 415.19</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Sleep Apnea 780.57</p> <p><input type="checkbox"/> Wheezing</p> <p>GASTROINTESTINAL:</p> <p><input type="checkbox"/> Cirrhosis 571.5</p> <p><input type="checkbox"/> Colitis 558.9</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> GERD(gastroesophageal reflux disease)530.11</p> <p><input type="checkbox"/> Hemorrhoids 455.6</p> <p><input type="checkbox"/> Hepatitis 573.3</p> <p><input type="checkbox"/> Inflammatory Bowel Disease 569.9</p> <p><input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> Stools, Bloody or black</p> <p>Ulcers <input type="checkbox"/> Stomach (531.90) <input type="checkbox"/> Duodenal (534.90)</p> <p>GENITAL SYSTEM: FEMALE:</p> <p><input type="checkbox"/> Menstrual irregularities</p> <p><input type="checkbox"/> Vaginal discharge or infection</p> <p>Last pelvic exam _____</p> <p>Number of pregnancies _____</p> <p>Number of live births _____</p> <p>GENITAL SYSTEM: MALE:</p> <p><input type="checkbox"/> Erectile dysfunction 302.72</p> <p><input type="checkbox"/> Penile discharge or infection</p> <p><input type="checkbox"/> Sores or lumps on scrotum, penis, testicles</p> <p>URINARY SYSTEM:</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Dribbling with cough or sneeze</p> <p><input type="checkbox"/> Excessive urination</p> <p><input type="checkbox"/> Infections of Urinary tract 599.0</p> <p><input type="checkbox"/> Kidney Failure 586</p> <p><input type="checkbox"/> Kidney stones 592.0</p> <p><input type="checkbox"/> Painful or burning urination</p> <p><input type="checkbox"/> Prostatic enlarged (BPH) 600.00</p> <p><input type="checkbox"/> Urinary retention</p>	<p>SKIN:</p> <p><input type="checkbox"/> Eczema 692.9 or <input type="checkbox"/> Rashes 782.1</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Psoriasis 696.1</p> <p><input type="checkbox"/> Non-healing lesions or sores</p> <p><input type="checkbox"/> Bothersome scars or colloids</p> <p>ENDOCRINE (GLANDS):</p> <p>Diabetes <input type="checkbox"/> Type I (250.01) <input type="checkbox"/> Type II (250.00)</p> <p><input type="checkbox"/> Hyperthyroid 242.90</p> <p><input type="checkbox"/> Hypothyroid 244.9</p> <p><input type="checkbox"/> Excessive sweating</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Heat or cold intolerance</p> <p>HEMATOLOGIC/LYMPHATIC:</p> <p><input type="checkbox"/> Anemia 285.9</p> <p><input type="checkbox"/> Bleeding problems</p> <p><input type="checkbox"/> Blood Clots Lower Extremity (DVT) 453.40</p> <p><input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> Hemophilia 286.0</p> <p><input type="checkbox"/> HIV Positive 042</p> <p><input type="checkbox"/> von Willebrand's disease 286.4</p> <p><input type="checkbox"/> Transfusion reactions 999.89</p> <p>NERVOUS SYSTEM:</p> <p><input type="checkbox"/> Alzheimer's Disease 331.0</p> <p><input type="checkbox"/> Balance problems</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting spells</p> <p><input type="checkbox"/> Headaches 784.0</p> <p><input type="checkbox"/> Memory loss 780.93</p> <p>Mononeuritis <input type="checkbox"/> Arms 354.9 <input type="checkbox"/> Legs 355.8</p> <p><input type="checkbox"/> Multiple Sclerosis 340</p> <p><input type="checkbox"/> Numbness or tingling</p> <p><input type="checkbox"/> Seizure Disorder 780.39</p> <p><input type="checkbox"/> Parkinson's Disease 332.0</p> <p><input type="checkbox"/> Polyneuropathy, Diabetic 357.2</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Weakness</p> <p>PSYCHOLOGICAL SYSTEM:</p> <p><input type="checkbox"/> Anxiety 300.02</p> <p><input type="checkbox"/> Bipolar Disorder 296.00</p> <p><input type="checkbox"/> Depression 311</p> <p><input type="checkbox"/> Mood changes</p> <p><input type="checkbox"/> Sleeping Problems</p>
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CANCER:

Type _____ Treating Physician _____

Treatment _____

OTHER PROBLEM:

Describe: _____

I certify that to the best of my knowledge the information on these 2 pages is correct.

Patient Signature _____ Print Patient Name _____ Date _____

I reviewed this data with patient and added it into the Aspen EMR _____

Physician Signature _____ Date _____