aspen
ORTHOPEDIC SPECIALISTS
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Date:______________________

Phone - **(262) 395-4141**

www.aspenors.com

PATIENT HISTORY FORM *(Please Print)*

Patient Name:____Age: ________ Date of Birth:____________

VISIT INFORMATION

Chief Complaint:______________________________Body Part:______________Date Started:__________________

Describe How Problem Started and its Course: ____

____

Doctor or person who referred you for this problem: ____

Have you been treated for this problem? ☐Yes ☐No If yes, by whom?____

Occupation:_________________________________ Shoe Size ______________ ☐Right handed ☐Left handed

Duties:____

TREATMENT you have had done for this problem *(X-rays, MRIs, CT Scans, Bone Scans, EMGs, EKGs, Injections, Medications, Therapy, etc.)*

Name of Test	Body Part Tested	Date of Test	Where Was Test Done?

VITAL SIGNS *(to be completed by Office Staff only)*

BP:______________________________ Temp:______________________________

Pulse:____________________________ Weight:____________________________

Resp:_____________________________ Height:____________________________

Tobacco Use

Current smoker? ☐Yes ☐No How many packs daily?_______ How many years? _______

Former smoker? ☐Yes ☐No Quit date?_______ Smokeless tobacco? ☐Current user ☐Former user ☐Never used

Alcohol Use

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

ALLERGIES

Are you allergic to any drugs, medications, latex, nickel, etc? ☐Yes ☐No

List Allergy	List Reaction(s) *(example: hives, skin rash, itching, shock, shortness of breath, fever, etc.)*
1)	
2)	
3)	
4)	
5)	

Patient Name:______________________________ Age: ________ Date of Birth:____________

MEDICATIONS *(THIS SECTION MUST BE COMPLETED)*
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	Frequency of Usage
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

PHARMACY
Name of pharmacy you'd like us to use for medications: ______________________________

Address:______________________________ Phone:______________

Bone, Joint, Muscle and Other Problems

Bone or Joint Infection	☐Yes	☐No	Deep Vein Thrombosis	☐Yes	☐No	Gout	☐Yes	☐No
Bursitis	☐Yes	☐No	Fractures	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No

Other______________________________

Surgical History

Ankle Fracture Surgery	☐Yes	☐No	Humerus Fracture Surgery	☐Yes	☐No	Other:______________
Arthroscopic Knee Surgery	☐Yes	☐No	Knee Replacement	☐Yes	☐No	______________
Arthroscopic Shoulder Surgery	☐Yes	☐No	Laminectomy	☐Yes	☐No	______________
Carpal Tunnel Release	☐Yes	☐No	Shoulder Replacement	☐Yes	☐No	______________
Elbow Fracture Surgery	☐Yes	☐No	Spinal Fusion	☐Yes	☐No	______________
Femur Fracture Surgery	☐Yes	☐No	Wrist Fracture Surgery	☐Yes	☐No	______________
Hip Replacement	☐Yes	☐No				______________

Medical History

Anemia	☐Yes	☐No	Depression	☐Yes	☐No	Osteoporosis	☐Yes	☐No
Arrhythmia	☐Yes	☐No	Diabetes Mellitus	☐Yes	☐No	Peripheral Arterial Disease	☐Yes	☐No
Arthritis	☐Yes	☐No	Gout	☐Yes	☐No	Prostate Cancer	☐Yes	☐No
Asthma	☐Yes	☐No	Hepatitis	☐Yes	☐No	Psoriasis	☐Yes	☐No
Bleeding Disorder	☐Yes	☐No	HIV/AIDS	☐Yes	☐No	Stomach Ulcer	☐Yes	☐No
Blood Clots	☐Yes	☐No	Hyperlipidemia	☐Yes	☐No	Stroke	☐Yes	☐No
Cancer	☐Yes	☐No	Hypertension	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
COPD	☐Yes	☐No	Liver Disease	☐Yes	☐No	Restricted Diet:______________		
Coronary Artery			Metal Allergy	☐Yes	☐No	Other Medical History:______________		
Disease	☐Yes	☐No	MRSA	☐Yes	☐No	______________		

YOU MUST PRINT THIS FORM OUT AND BRING IT WITH YOU TO YOUR APPOINTMENT.
THIS FORM DOES NOT AUTOMATICALLY GET SENT TO ASPEN.
IF YOU DO NOT PRINT THIS FORM OUT, THE INFORMATION WILL BE LOST.