aspen
ORTHOPEDIC SPECIALISTS
Experience. Excellence.

Date: _____

Phone: (262) 395-4141

www.aspenors.com

PATIENT HISTORY FORM (Please Print)

Patient Name: _____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? _____

Is this related to a motor vehicle accident? ☐ Yes ☐ No Is this a personal injury? ☐ Yes ☐ No

*If yes to either, who is responsible? _____

Is this a work-related injury? ☐ Yes ☐ No Is an attorney involved? ☐ Yes ☐ No *If yes, name: _____

Employer: _____ Work Phone _____

Occupation: _____ Shoe Size _____ ☐ Right-handed ☐ Left-handed

Duties:_____

TREATMENT you have done for this problem (x-rays, MRI, CT Scans, EMGs, EKGs, Injections, Medications, Therapy, etc.)

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

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

Fall Risk

Have you fallen in the past year? ☐ Yes ☐ No If yes: ☐ Once ☐ Two or more times? Did the fall result in injury? ☐Yes ☐No

Vital Signs: (*For employee use only*) Temp: _____ Height: _____ Weight: _____

ALLERGIES

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

List Allergy and Reaction(s) ***(i.e., hives, skin rash, itching, shock, shortness of breath, fever, etc.)***

1)_____

2)_____

3)_____

4)_____

MEDICATIONS ***(THIS SECTION MUST BE COMPLETED)***

List all prescription drugs, over-the-counter medicinces, herbal remedies, inhalers, birth control pills, diet pills, blood thinners (Coumadin, Warfarin, Lovenox, Plavix, Aspirin, etc.)

Name of Medication(s)	Dosage	Frequency of use
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

PHARMACY:

Name of Pharmacy you would like us to use for medications: _____

Address: _____ Phone: _____

BONE, JOINT, MUSCLE and OTHER PROBLEMS *check all that apply

- ☐ Bone or Joint Infection
- ☐ Bursitis
- ☐ Other_____
- ☐ Deep Vein Thrombosis
- ☐ Fractures
- ☐ Gout
- ☐ Rheumatoid Arthritis

SURGICAL HISTORY *Check all that apply

- ☐ Ankle Fracture Surgery
- ☐ Arthroscopic Knee Surgery
- ☐ Arthroscopic Shoulder Surgery
- ☐ Carpal Tunnel Release
- ☐ Elbow Fracture Surgery
- ☐ Femur Fracture Surgery
- ☐ Hip Replacement
- ☐ Humerus Fracture Surgery
- ☐ Knee Replacement
- ☐ Laminectomy
- ☐ Shoulder Replacement
- ☐ Spinal Fusion
- ☐ Wrist Fracture Surgery
- ☐ Other:_____
  _____
  _____
  _____
  _____
  _____
  _____

MEDICAL HISTORY *Check all that apply

- ☐ Anemia
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Cancer – Type: _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Liver Disease
- ☐ Metal Allergy
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Peripheral Arterial Disease
- ☐ Psoriasis
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Restricted Diet: _____
- ☐ Other: _____