aspen
ORTHOPEDIC SPECIALISTS
Experience. Excellence.

Phone - **262/395-4141**

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Brookfield PT – 2205 N. Calhoun Road, #17
New Berlin - 12555 W. National Avenue, Suite 100

www.aspenors.com

Date:_____

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:_____ ☐Right handed ☐Left handed Shoe Size_____

Duties:_____

TREATMENT you have had done for this problem *(X-rays, MRI's, CT Scans, Bone Scans, EMG's, EKG's, Injections, Medications, Therapy, and so forth)*

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, jewelry, 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 (ex: Naproxen, Mobic, Meloxicam, Celebrex, etc.), over the counter medicines (ex: Ibuprofen, Aleve, etc.), herbal remedies, inhalers, birth control pills, diet pills, blood thinners (ex: 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	Shoulder/Humerus Fracture Surgery	☐Yes	☐No	Other:_____	
Arthroscopic Knee Surgery	☐Yes	☐No	Knee Replacement	☐Yes	☐No	_____	
Arthroscopic Shoulder Surgery	☐Yes	☐No	Laminectomy/Spine Surgery	☐Yes	☐No	_____	
Carpal Tunnel Release	☐Yes	☐No	Shoulder Replacement	☐Yes	☐No	_____	
Elbow Fracture Surgery	☐Yes	☐No	Spinal Fusion	☐Yes	☐No	_____	
Thigh/Femur Fracture Surgery	☐Yes	☐No	Wrist Fracture Surgery	☐Yes	☐No	_____	
Hip Replacement	☐Yes	☐No				_____	

Medical History

Anemia/Low Blood Count	☐Yes	☐No	Depression	☐Yes	☐No	Osteoporosis/Brittle Bones	☐Yes	☐No
Arrhythmia/Irregular Heartbeat	☐Yes	☐No	Diabetes Mellitus	☐Yes	☐No	Peripheral Arterial Disease/Poor Circulation	☐Yes	☐No
Arthritis	☐Yes	☐No	Hepatitis	☐Yes	☐No	Psoriasis/Skin Rashes	☐Yes	☐No
Asthma	☐Yes	☐No	HIV/AIDS	☐Yes	☐No	Stomach Ulcer/Heartburn/Reflux	☐Yes	☐No
Bleeding Disorder	☐Yes	☐No	Hyperlipidemia/High Cholesterol	☐Yes	☐No	Stroke	☐Yes	☐No
Blood Clots	☐Yes	☐No	Hypertension/High Blood Pressure	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Cancer	☐Yes	☐No	Liver Disease	☐Yes	☐No	Restricted Diet:_____		
COPD	☐Yes	☐No	Metal Allergy/Rash from Jewelry	☐Yes	☐No	Other Medical History:_____		
Coronary Artery Disease	☐Yes	☐No	MRSA/Resistant Staph Infection	☐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.