Patient Account # _____

MEDICAL STAFF TO COMPLETE

HT _____ WT _____

BP _____ Pulse _____ Temp. _____

Both sides of this form (history and review of systems) reviewed by:

Physician Signature _____ Date _____

Name: _____ Date: _____ Sex: ☐ M ☐ F

Age: _____ Circle: RIGHT or LEFT handed Occupation: _____

Marital Status: S M W D

Reason for being seen: _____

Circle: RIGHT or LEFT side

How did it start? Was there a specific injury? _____

_____

When did it start? List date of injury or first symptom: _____

_____

What treatments have you tried? _____

PT/OT : _____ Anti Inflammatories: _____ Injections: _____

What makes it worse? _____

_____

Work Related? YES or NO

Previously related problems: _____

Primary Care Physician: _____ Did he or she send you to us? YES or NO

How did you hear about the Milwaukee Orthopaedic Group? _____

MEDICAL HISTORY: *(Please circle when appropriate)*

High Blood Pressure	Heart Disease	HIV	Asthma
Kidney Disease	Diabetes	Infection	Cancer
Abdominal Disease	Hepatitis	Ulcer or GI Difficulty	Osteoporosis

Any family/personal history: DVT, clotting/bleeding disorders _____

Other _____

Previous Surgery: _____

_____

Medications: _____

_____

Pharmacy Name: _____ Street/City _____ Phone: _____

Allergies: _____

Alcohol Intake: YES NO Tobacco Use: YES NO Recreational Drugs: YES NO

How much? _____ How much? _____ How much? _____

How long? _____ How long? _____ How long? _____

Do you have a family history of any hereditary diseases? If yes, please specify _____

_____

Have you had a bone density test? YES NO If yes, when: _____

OVER

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NAME _____

REVIEW OF SYSTEMS

HAVE YOU HAD, OR ARE YOU HAVING PROBLEMS WITH:

SKIN
____ abnormal color changes
____ itching
____ easy bruising
____ rashes
____ infections
____ none of the above

BLEEDING PROBLEMS
____ any history of anemia
____ any blood transfusions
____ problems with blood transfusions
____ chronic nose bleeds
____ any enlarged lymph nodes
____ increased surgical bleeding
____ history of bloodclots
____ none of the above

HEAD
____ chronic headaches
____ facial trauma/paralysis
____ sleep apnea
____ snoring
____ none of the above

EARS
____ hearing aids
____ ear pain
____ ringing in ears
____ deafness
____ none of the above

EYES
____ glasses/contacts
____ double vision
____ blurred vision
____ burning
____ infections
____ none of the above

NOSE/SINUSES
____ chronic nose bleeds
____ nasal obstruction
____ fractured nose
____ trouble breathing
____ post nasal drip
____ chronic drainage
____ none of the above

MOUTH/THROAT
____ sores
____ bleeding gums
____ dentures/bridges
____ sore throat
____ missing teeth
____ none of the above

RESPIRATORY
____ chronic cough
____ cough up phlegm
____ cough up blood
____ wheezing
____ night sweats
____ none of the above

CARDIAC
____ chest pain
____ shortness of breath
____ chest pain with exertion
____ leg swelling
____ palpitations
____ heart murmur
____ calf pain with exertion
____ varicose veins
____ none of the above

GASTROINTESTINAL
____ decreased appetite
____ chronic thirst
____ chronic nausea
____ vomiting
____ vomiting blood
____ chronic gas
____ chronic belching
____ trouble swallowing
____ heartburn
____ stomach pain
____ jaundice
____ irregular bowel movements
____ diarrhea
____ constipation
____ hemorrhoids
____ hernias
____ none of the above

URINARY TRACT
____ pain with urination
____ burning with urination
____ blood in urine
____ history of kidney stones
____ frequency at night
____ frequency during the day
____ infections
____ none of the above

GENITAL TRACT (MALE)
____ unusual discharge
____ lesions
____ hernias
____ masses
____ pain
____ none of the above

GENITAL TRACT (FEMALE)
____ no. of pregnancies
____ no. of children
____ history of UTIs
____ none of the above

NERVOUS SYSTEM
____ convulsions
____ dizziness
____ passing out
____ tremors
____ speech difficulty
____ weakness/paralysis
____ numbness
____ tingling
____ none of the above

ENDOCRINE
____ goiter
____ heat or cold intolerance
____ chronic sweating
____ voice change
____ painful swallowing
____ none of the above

PSYCHIATRIC
____ irritability
____ memory loss
____ depression
____ insomnia
____ nightmares
____ none of the above

ALLERGY
SENSITIVITY TO:
____ metal/metal jewelry
____ aspirin
____ latex
____ adhesives
____ problems with anesthesia
____ other_____
____ none of the above

X _____
(Patient Signature) (Date)

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.

OWNERSHIP DISCLOSURE NOTICE

Please be advised that Dr. Patrick W. Jost and Dr. Ryan M. Graf have an ownership interest in the Orthopaedic Hospital of Wisconsin. In the course of your diagnosis and/or treatment at our office, you may be referred for services at the Orthopaedic Hospital of Wisconsin. If you prefer that the services for which you are referred be provided at a different facility, please notify one of our staff members at, or as soon as possible after, the time of such referral so that alternative arrangements can be made.

_____ _____

Name of Patient | Signature of Patient/Personal Representative

_____/_____/_____ _____

Date Signed | Relationship to Patient if signed by Personal Representative