milwaukee orthopaedic group limited

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

How much? _____

How long? _____

Tobacco Use: YES NO

How much? _____

How long? _____

Recreational Drugs: YES NO

How much? _____

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)