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: _____ ☐ RIGHT or ☐ LEFT handed Occupation: _____

Marital Status: ☐ S ☐ M ☐ W ☐ D

Reason for being seen: _____

☐ 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? ☐ YES ☐ NO Name and location: _____

Anti-inflammatories? ☐ YES ☐ NO _____ Injections? ☐ YES ☐ NO _____

What makes it worse? _____

Work Related? ☐ YES ☐ NO Are you or have you filed a workers' compensation claim? ☐ YES ☐ NO

Previously related problems: _____

Primary Care Physician name and location: _____

Did he or she send you to us? ☐ YES ☐ NO

How did you hear about the Milwaukee Orthopaedic Group? _____

MEDICAL HISTORY: *(Please check 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

milwaukee orthopaedic group limited

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 blood clots
- ☐ 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)