WISCONSIN RIVER ORTHOAPEDICS, LTD

History and Intake Form Name:_____Birthday:_____Age:_____

Chief Complaint: (Please list current symptoms, including any injuries and their duration) _____

_____

Primary or Referring Physician:_____ Preferred Pharmacy:_____

Review of Systems: Have you experienced any of these in the past week?

Joint/Limb Pain	Joint Stiffness	Unsteady Gait	Joint Swelling	Numbness/Tingling
Fever/Chills	Chest Pain	Shortness of Breath	Cough	Rash/Itching
Non-healing Wound	Heartburn/GERD	Bowel Difficulties	Urinary Problems	Depression
Easy Bleeding	Nose Bleeds	Heat/Cold Intolerance		

Past Medical History (Please check all that apply)

Anemia	Diabetes	High Blood Pressure
Anxiety	DVT/Blood Clot	Hyperthyroidism
Asthma	End Stage Renal Disease	Hypothyroidism
Atrial Fibrillation	Fibromyalgia	Lyme's Disease/when:_____
Cancer: Type:_____	GERD	Obesity
Chronic pain	Hepatitis	PBPH
COPD	HIV/AIDS	Radiation Therapy
Coronary artery Disease	High Cholesterol	Seizures
Depression	Hyperparathyroidism	Stroke

Other_____

Past Surgical History (Please check all that apply)

Appendix	Gastric Bypass	Kidney Stone Removal
Bladder removed	Heart:Valve Replacement	Prostate Removal/TURP
Breast Mastectomy: R L Both	Heart:Coronary Artery Bypass (CABG)	Skin:_____
Breast Lumpectomy: R L Both	Hysterectomy	Tonsillectomy/Adenoidectomy
Colectomy: Colon cancer resection	Oophorectomy	Transplant:_____
Gallbladder removal	Tubal Ligation	

Other:_____

Past Orthopaedic History (Please check all that apply)

Ankle fracture	Metastatic bone disease	Sciatica
Ankylosing spondylitis	Osteoporosis	Scoliosis
Bursitis	Osteoarthritis	Spine fracture
Epidural injections, spine	Osteopenia	Sarcoma:_____
Fracture:_____	Psoriatic arthritis	Spinal stenosis
Gout	Rheumatoid Arthritis	Compression Fracture
Hip Fracture	Wrist Fracture	Vitamin D deficiency

Other_____

Past Orthopaedic Surgery (Please check all that apply)

Ankle fracture ORIF: R L Both	Intermedullary nailing: Tibia R L	Kyphoplasty/Vertebroplasty
Carpal tunnel release: R L Both	Joint Replacement: Hip R L Both	L-Spine: Decompression
C-Spine surgery: ACDF	Joint Replacement: Knee R L Both	L-Spine: Fusion
C-Spine: Disc replacement	Joint Replacement: Shoulder R L Both	L-Spine: Disc replacement
Radius (wrist) ORIF: R L Both	Knee arthroscopy: R L Both	Rotator Cuff Repair: R L Both
Intermedullary nailing: Femur R L	**Other**:_____	

Medications and Vitamins (Please list ***ALL*** current)	**Dosage**	**Medication/Vitamin** (Please list ***ALL*** current)	**Dosage**

Allergies (Include ***ALL*** allergies, metals, latex, drugs, etc.)	**Reaction**	**Allergies** (Include ***ALL*** allergies, metals, latex, drugs, etc.)	**Reaction**

Do you have a metal allergy? Yes_____ No_____ Type of reaction:_____

Family History (Has any first degree **blood relative** had any of the following?) ADOPTED:_____

	Mother	**Father**	**Sister**	**Brother**	**Grandma**	**Grandpa**	**Other**
High Blood Pressure							
High Cholesterol							
Osteoarthritis							
Rheumatoid arthritis							
Gout							
Cancer							
Diabetes							
Other:							

Patient Information

Preferred Language:_____Race:_____Ethnicity: _____

Do you have an Advance Care Plan (living will, power or attorney for health care)? YES/NO

Did you receive a Flu vaccination for this flu season? YES/NO If no, Why?_____

Social History

Smoker: Yes_____ ppd_____Former_____ Never_____ Illicit drug use: _____

Alcohol use: Yes_____ No_____ Amount:_____

a.) Women: How many times in the past year have you had 4 or more alcoholic drinks in one episode?_____
b.) Men: How many times in the past year have you had 5 or more alcoholic drinks in one episode?_____

Right handed_____ Left handed_____ Marital Status:_____

Occupation (if retired past employment): _____ Full time/Part time/Unemployed/Disabled

The above information is accurate to the best of my knowledge:

Patient Signature:_____Date:_____