WISCONSIN RIVER ORTHOPAEDICS

History Intake Form, Page 1

Patient name: _____ Birthdate:_____ Age:_____

Circle: Right-handed/Left-handed Occupation (If retired, past profession):_____

Marital status: _____
Primary care Dr.: _____ Referring Dr. (if different): _____

Do you smoke? Yes/No ppd _____
Are you a former smoke? Yes/No; If yes, when did you quit? _____
Do you drink alcohol? Yes/No; If yes, how many drinks per day? _____

Body part being seen for today (R) or (L): _____ Date of Onset of symptoms: _____

Brief description of injury: _____
_____

Please rate your pain (0=none, 10=worst): _____

How is your current problem limiting you?:
_____
_____

Are you taking medications specifically for this? If so, which medications?
_____
Please list **ALL** medical problems (heart, lungs, diabetes, cancer, etc.):_____
_____
_____

Please list **ALL** previous surgeries (orthopaedic **AND** non-orthopaedic):_____
_____
_____

Do **you** have or have you had any of the following (circle)?:

MRSA/MSSA	Blood Clot	Blood disorder	Cancer	Osteoarthritis	Rheumatoid Arthritis	Gout

Does any first degree **blood relative** have or has had any of the following (check box):

	Mother	Father	Brother	Sister
Diabetes				
Rheumatoid arthritis				
Osteoarthritis				
Blood clots				
Blood disorder				

REVIEW of Systems (Circle all that apply currently to you):

Joint/Limb Pain Numbness/Tingling Fever/Chills Chest Pain

Shortness of Breath Non-healing wound Acid Reflux Easy Bleeding

(office use only)
Weight: _____

Height: _____

BMI: _____

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History Intake Form, Page 2

Patient name: _____ Birthdate:_____

Pharmacy of Choice: _____

ALLERGIC to (circle all that apply): LATEX METAL IODINE/SHELLFISH

LIST MEDICATION ALLERGIES and the allergic REACTION:

Medication	Reaction	Medication	Reaction
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

CURRENT MEDICATIONS/ SUPPLEMENTS (name of medication and dosage):

Medication	Dosage	Frequency	Medication	Dosage	Frequency
1.			16.		
2.			17.		
3.			18,		
4.			19.		
5.			20.		
6.			21.		
7.			22.		
8.			23.		
9.			24.		
10.			25.		
11.			26.		
12.			27.		
13.			28.		
14.			29.		
15.			30.		

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

Patient signature _____ Date: _____