ASPEN Orthopedics
www.aspenors.com

Phone - **262/395-4141**

Brookfield - 19475 W. North Avenue, Suite 201
New Berlin - 12555 W. National Avenue, Suite 100
Pewaukee - 2900 Golf Road, Third Floor

Date:_____

PATIENT HISTORY FORM *(Please Print)*

Patient Name:_____ Age: _____ Date of Birth:_____

VISIT INFORMATION

Chief Complaint:_____ Body Part:_____ Date Started:_____

Describe How Problem Started and its Course: _____

_____

Doctor or person who referred you for this problem: _____

Have you been treated for this problem? ☐Yes ☐No If yes, by whom?_____

Occupation:_____ ☐Right handed ☐Left handed

Duties:_____

TREATMENT you have had done for this problem ***(X-rays, MRI's, CT Scans, Bone Scans, EMG's, EKG's, Injections, Medications, Therapy, and so forth)***

Name of Test	Body Part Tested	Date of Test	Where Was Test Done?

VITAL SIGNS ***(to be completed by Office Staff only)***

BP:_____ Temp:_____

Pulse:_____ Weight:_____

Resp:_____ Height:_____

Tobacco Use

Do you smoke? ☐Yes ☐No How many packs daily?_____ How many years? _____ When stopped?_____

Alcohol Use

Do you drink alcohol? ☐Yes ☐No ☐Less than 1 drink daily ☐1-2 drinks daily ☐3 or more daily

ALLERGIES

Are you allergic to any drugs, medications, latex, nickel, etc? ☐Yes ☐No

List Allergy	List Reaction(s) *(example: hives, skin rash, itching, shock, shortness of breath, fever, etc.)*
1)_____	
2)_____	
3)_____	
4)_____	
5)_____	

Patient Name:_____ Age: _____ Date of Birth:_____

MEDICATIONS

List all prescription drugs, over the counter medicines, herbal remedies, inhalers, birth control pills, diet pills, blood thinners (Coumadin, Warfarin, Lovenox, Plavix, Aspirin, etc.) you are currently taking.

Name of Medication(s)	Dosage	Frequency of Usage
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

PHARMACY

Name of pharmacy you'd like us to use for medications: _____

Address:_____ Phone:_____

Bone, Joint, Muscle and Other Problems

Bone or Joint Infection	☐Yes	☐No	Deep Vein Thrombosis	☐Yes	☐No	Gout	☐Yes	☐No
Bursitis	☐Yes	☐No	Fractures	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No

Other_____

Medical History

Allergies	☐Yes	☐No	Depression	☐Yes	☐No	Nerve Muscle Disease	☐Yes	☐No
Anemia	☐Yes	☐No	Diabetes Mellitus	☐Yes	☐No	Osteoporosis	☐Yes	☐No
Anxiety	☐Yes	☐No	Emphysema	☐Yes	☐No	Seizures	☐Yes	☐No
Arthritis	☐Yes	☐No	GERD	☐Yes	☐No	Sickle Cell Anemia	☐Yes	☐No
Asthma	☐Yes	☐No	Glaucoma	☐Yes	☐No	Stroke	☐Yes	☐No
Blood Transfusion	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Substance Abuse	☐Yes	☐No
Cancer	☐Yes	☐No	HIV/AIDS	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Cataracts	☐Yes	☐No	Hypertension	☐Yes	☐No	Tuberculosis	☐Yes	☐No
CHF	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Ulcers	☐Yes	☐No
Clotting Disorder	☐Yes	☐No	Meningitis	☐Yes	☐No	Restricted Diet:_____		
COPD	☐Yes	☐No	Myocardial Infarction	☐Yes	☐No	Other Medical History:_____		

Surgical History

Appendectomy	☐Yes	☐No	Cosmetic Surgery	☐Yes	☐No	Joint Replacement	☐Yes	☐No
Brain Surgery	☐Yes	☐No	C-Section	☐Yes	☐No	Small Intestine Surgery	☐Yes	☐No
Breast Surgery	☐Yes	☐No	Eye Surgery	☐Yes	☐No	Spine Surgery	☐Yes	☐No
CABG	☐Yes	☐No	Fracture Surgery	☐Yes	☐No	Tubal Ligation	☐Yes	☐No
Cholecystectomy	☐Yes	☐No	Hernia Repair	☐Yes	☐No	Valve Replacement	☐Yes	☐No
Colon Surgery	☐Yes	☐No	Hysterectomy	☐Yes	☐No	Other Surgical History:_____		