ORTHOPAEDIC ASSOCIATES OF WAUSAU PATIENT HEALTH HISTORY FORM

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible.

Full Name: _____ Gender: _____ Date of Birth: _____

Do you have an Advanced Directive? Yes ☐ No ☐ If no, would you like information on how to get one set up? Yes ☐ No ☐

Medication List: *List prescribed medications, vitamins, herbal, inhalers, and/ or diet supplements.*

Medication	Dosage	Reason for taking this medication

Allergies:

Type	Reaction

Do you have any of the following:

Allergy to any of the following?		
Adhesive Tape	☐ No	☐ Yes
Iodine	☐ No	☐ Yes
Contrast Dye	☐ No	☐ Yes
Metal	☐ No	☐ Yes
Latex	☐ No	☐ Yes
Family history of Malignant Hyperthermia	☐ No	☐ Yes

Implanted devices:_____
Prosthesis (type): _____
Hearing aid (R/L): _____
Dentures/ Partial (upper/lower): _____
Glasses/ contacts (R/L): _____
Are you Right ☐ or Left ☐ handed

Do you have any history of:

- ☐ High Blood Pressure
- ☐ Frequent Headaches
- ☐ Ulcer
- ☐ GERD
- ☐ Stomach Pain
- ☐ Diabetes, type _____
- ☐ Mental Illness
- ☐ Spinal Cord injury
- ☐ Blood Clots
- ☐ HIV/ AIDS
- ☐ Jaundice/ Liver Disease
- ☐ Kidney Disease
- ☐ Heart Attack
- ☐ ADHD
- ☐ Angina
- ☐ Heart Murmur
- ☐ Sleep Apnea
- ☐ Anemia
- ☐ Seizures/ Epilepsy
- ☐ Stroke
- ☐ Fainting Spells
- ☐ Paralysis
- ☐ Eczema/ Psoriasis
- ☐ Raynaud's Syndrome
- ☐ Anxiety
- ☐ Depression
- ☐ COPD
- ☐ Arthritis, type_____
- ☐ Cancer, type _____
- ☐ Excessive Bleeding
- ☐ High Cholesterol/ Lipids
- ☐ Blood Transfusion
- ☐ Thyroid Disease
- ☐ Sickle Cell Disease
- ☐ Asthma
- ☐ Bronchitis
- ☐ Numbness, location _____
- ☐ Tingling, location_____
- ☐ Other _____

If you ever received a cortisone or steroid injection, please list the body part and how many times it has been injected. _____

_____

Surgeries:

Procedure	Hospital	Date

Family Health History:
Please list any problems that run in your family to include bad reactions to anesthesia, easily bruised or bleeding, diabetes, cancer, heart attack before age of 55, arthritis, etc.

	Age	Gender	Significant Health Problems		Age	Gender	Significant Health Problems
Father				Child		☐ M ☐ F	
Mother				Child		☐ M ☐ F	
Sibling		☐ M ☐ F		Child		☐ M ☐ F	
Sibling		☐ M ☐ F		Grandparents		☐ M ☐ F	

Bone Health: *Check any of the below that you have had.*

☐ Fracture from a fall or low impact injury
☐ Fracture of the wrist, spine or hip
☐ Vitamin D Deficiency
☐ Frequent falls
☐ Long term use of steroids (Name of steroid and what you took it for)
_____
☐ Had a Bone Mineral Density Test (DXA Scan). If yes, when and where?
_____
☐ Had treatment for Osteoporosis. If yes, what and when?
_____

Social History:

☐ Work in the home?	☐ Employed (occupation_____)		☐ Student	☐ Daycare	☐ Retired
☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widowed	
Children? ☐ No	☐ Yes	How many? _____			
Do you live alone? ☐ No	☐ Yes				
Exercise? ☐ Daily	☐ Weekly	☐ Monthly	☐ Rarely	☐ Never	
What type of exercise? _____					
History of substance abuse? ☐ No	☐ Yes	What? _____			
Have you ever been or are you currently on a pain contract? ☐ No	☐ Yes	With Whom? _____			
Current Tobacco User? ☐ No	**Type:** ☐ Cigarettes: Packs/quantity per day _____		☐ E-Cig/Vape	☐ Smokeless Tobacco	
Quit smoking? ☐ This year	☐ Less than a year	☐ Less than five years	☐ Less than 10 years		
Previously smoked _____ packs per day for _____ years.					
Drink alcohol? ☐ No	☐ Daily	☐ 1-2 times a week	☐ 1-2 times per month	☐ 1-2 times per year	

Patient Signature: _____ Date: _____

***** ONLY COMPLETE IF YOU ARE HERE FOR PRO PHYISCAL THERAPY: *****

Reason for attending therapy? _____
Date symptoms occurred: _____ Cause of your injury: _____
What makes your symptoms worse: _____
What makes your symptoms better (please circle): Ice Heat Meds Rest Activity Massage Other: _____
Main Goal(s) for Therapy: _____
Have you ever had treatment for this problem before: ☐ Yes ☐ No

- If Yes, what kind of treatment have you had (please circle): PT OT Chiropractic Massage Therapy Other: _____

What is your preferred learning style(s) (please circle): visual/seeing auditory/hearing tactile/doing (performance)
Is this Worker's Compensation: ☐ Yes ☐ No

- If yes, do you have work restrictions? ☐ Yes ☐ No If yes, what are they: _____
- How many hours a week do you normally work? _____
- Have you returned to work? ☐ Yes ☐ No
  - If yes, at what capacity? How many hours per week are you currently working? _____
  - Are you performing your normal work duties? ☐ Yes ☐ No If No, please explain: _____

Patient Signature: _____ Date: _____