ORTHOPAEDIC ASSOCIATES OF WAUSAU / PRO PHYSICAL THERAPY & HAND CENTER 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.

Social Security Number (SSN):_____ Appointment Date_____

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 ☐

Do you have an activated Power of Attorney for your healthcare decisions? Yes ☐ No ☐

If yes, who is your POA? _____

Relationship of POA: _____ Telephone Number: _____

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

Medication	Dosage	Reason for taking this medication

Allergies:

Type	Reaction

Non-Medication Allergies:

Are you allergic 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 Hypothermia	☐ No	☐ Yes

Do you have any of the following?

Implanted devices:_____
Prosthesis (type): _____
Hearing aid (R/L): _____
Dentures/ Partial (upper/lower): _____
Glasses/ contacts (R/L): _____
If you ever received a cortisone or steroid injection, please list the body part and how many times it has been injected.
_____

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
- ☐ Angina
- ☐ Heart Murmur
- ☐ Sleep Apnea
- ☐ Anemia
- ☐ Seizures/ Epilepsy
- ☐ Stroke
- ☐ Fainting Spells
- ☐ Paralysis
- ☐ Eczema/ Psoriasis
- ☐ Raynaud's Syndrome
- ☐ ADHD
- ☐ Depression
- ☐ Arthritis, type_____
- ☐ Cancer, type _____
- ☐ Excessive Bleeding
- ☐ High Cholesterol/ Lipids
- ☐ Blood Transfusion
- ☐ Thyroid Disease
- ☐ Sickle Cell Disease
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Other_____

Surgeries:

Procedure	Hospital	Date

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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? _____

Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What type of exercise? _____

History of substance abuse? ☐ No ☐ Yes What? _____

Current tobacco use? ☐ No ☐ Yes Type: ☐ Cigarette ☐ Vaping ☐ Chew ☐ Other: _____ Packs/quantity per day ____ for____ years.

Quit tobacco use? ☐ This year ☐ Less than a year ☐ Less than five years ☐ Less than 10 years

Previously smoked _____ packs per day for _____ years.

Drink alcohol? ☐ Daily ☐ 1-2 times a week ☐ 1-2 times per month 1-2 times per year

Review of Systems:
Mark yes or no and CHECK any of the following you have recently had:

Constitutional Symptoms ☐ **No** ☐ **Yes**
☐ Fatigue ☐ Fever ☐ General aching ☐ Night sweats
☐ Unintentional weight gain ☐ Unintentional weight loss

Eye Problems ☐ **No** ☐ **Yes**
☐ Blurred vision ☐ Red eye ☐ Sensitivity to light

Cardiovascular Problems ☐ **No** ☐ **Yes**
☐ Blacking out or fainting ☐ Chest pain
☐ Irregular heart beat

Respiratory Problems ☐ **No** ☐ **Yes**
☐ Frequent productive cough Shortness of breath
☐ Wheezing

Abdominal Pain ☐ **No** ☐ **Yes**
☐ Change in bowel habits ☐ Nausea ☐ Vomiting

Neurologic Problems ☐ **No** ☐ **Yes**
☐ Difficulty walking ☐ Numbness ☐ Tingling

Psychiatric Problems ☐ **No** ☐ **Yes**
☐ Feels nervous (anxiety) ☐ Feels sad (depression)
☐ Trouble sleeping

Endocrine Problems ☐ **No** ☐ **Yes**
☐ Feels cold

Hematologic/ Lymphatic Problems ☐ **No** ☐ **Yes**
☐ Bruises easily

Allergic, Infectious, Immunologic ☐ **No** ☐ **Yes**
☐ Infections recurring

Patient Signature: _____ Date: _____

TO ALL FEMALE PATIENTS: For your safety, if you are pregnant or think you may be pregnant, inform the doctor prior to your x-ray examination.