WISCONSIN RIVER ORTHOPAEDICS, LTD
History Intake Form – Dr. Todd Duellman

Patient name: _____ Birthdate:_____ Age:_____

Circle one: Right-handed/Left-handed Occupation: _____

Marital status: _____ Primary or Referring Physician: _____

Do you smoke? Yes/No ppd _____ Do you use alcohol? Yes/No
Are you a former smoke? Yes/No; If yes, when did you quit? _____

Body part being seen for today (R) or (L): _____ 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?
_____

Please list **ALL** medical problems (heart, lungs, diabetes, cancer, etc.):_____
_____
_____

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

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

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

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

Gout	MRSA/MSSA	Rheumatoid arthritis	Blood clots
Cancer	Blood disorder	Lyme disease	Osteoarthritis

(office use only)
Weight: _____

Height: _____

BMI: _____

Wisconsin River Orthopaedics

NAME: **DATE OF BIRTH:**

MEDICATION ALLERGIES/REACTION: **PHARMACY NAME:**

☐ LATEX ☐ METAL ☐ IODINE/SHELLFISH

CURRENT MEDICATIONS (name of medication only):

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

Patient signature _____ **Date:** _____