Northern Wisconsin Bone & Joint Center
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form.

Patient's Last Name_____**First** _____ **MI** _____

Sex ☐ Male ☐ Female **Date of Birth:** _____ **Social Sec #:**_____

Do you currently Work?
☐ YES ☐ NO If yes, where? _____

Retired?
☐ YES ☐ NO

Name of Primary Care Physician: _____

Pharmacy Preference (include location):_____

****Will you allow us to access your medication history from external sources if it is available?**

Please check. ☐ YES ☐ NO

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage (ex: 50 mg)	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION?

Please check. ☐ YES ☐ NO If yes, please list below:

Name of Medication	Reaction	Name of Medication	Reaction
1.		2.	
3.		4.	
5.		6.	

SURGERIES and HOSPITALIZATIONS.

Have you ever had any problems with anesthesia (being numbed or put to sleep)?

Please check. ☐ YES ☐ NO **If yes, please explain** type of anesthesia & problems (if you know):

_____

Surgery and/or Hospitalizations	Right or Left Side (circle)	Date	Surgeon/Hospital
	Right Left		
	Right Left		
	Right Left		

Use back side for addition to any of the lists: