STEVENS POINT ORTHOPEDICS

Dr. James Banovetz, PhD
Dr. Thomas Guse
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World Class Treatment... Hometown Care

HEALTH INFORMATION

Date _____/_____/_____

Name_____ DOB _____/_____/_____

Referring Physician: _____ Primary Care Physician:_____

Are you a: ☐ Recreational Athlete ☐ Competitive Athlete Team/Sport_____

Employer: _____ Occupation: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Education Level: ☐ High School ☐ 2 Yr College Degree ☐ 4 Yr College Degree ☐ Graduate School

Do you currently smoke/vape/or use e-cig? **N** or _____packs/day Have you ever smoked? **Y** **N**

Chew tobacco? **Y** **N** Drink Alcohol? **N** or _____drinks/day

Past Medical History

Alcohol Dependence	**Y N**		Diabetes Type I	**Y N**		Osteoarthritis	**Y N**
Anesthetic Problems	**Y N**		Diabetes Type II	**Y N**		Osteopenia	**Y N**
Anxiety	**Y N**		Gout	**Y N**		Osteoporosis	**Y N**
Arthritis	**Y N**		Heart Attack	**Y N**		Positive Bone Density	**Y N**
Asthma	**Y N**		Heart Murmur	**Y N**		Pseudo Gout	**Y N**
Atherosclerosis	**Y N**		High Blood Pressure	**Y N**		Rheumatoid Arthritis	**Y N**
Bleeding Problems	**Y N**		High Cholesterol	**Y N**		Skin Problems	**Y N**
Blood Clots	**Y N**		HIV Infection	**Y N**		Sleep Apnea	**Y N**
Cancer	**Y N**		Lupus	**Y N**		Stomach Ulcers	**Y N**
Coronary Artery Disease	**Y N**		Lyme Disease	**Y N**		Stroke	**Y N**
Dental Infection	**Y N**		Lung Problems	**Y N**		Thyroid Problem	**Y N**
Depression	**Y N**		MRSA	**Y N**		**None of the Above**	☐

Other: _____

Surgical History

_____

_____

Family Medical History

☐ First Degree Relatives have no current problems or disabilities

☐ Unknown

	Father	Mother	Brother(s)	Sister(s)	Son(s)	Daughter(s)
Anesthetic Problems	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Atherosclerosis	☐	☐	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Coronary Artery Disease	☐	☐	☐	☐	☐	☐
Diabetes Type I	☐	☐	☐	☐	☐	☐
Diabetes Type II	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐
Heart Murmur	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Lung Problems	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Pseudo Gout	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐
Skin Problems	☐	☐	☐	☐	☐	☐
Stomach Ulcers	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Problem	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

Patient Signature _____ **Date** _____