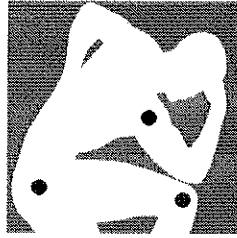


John S. Rogerson, MD

Donald L. Wackwitz



2 Science Court, Suite 101  
Madison, WI 53711

Phone: (608) 231-3410

Fax: (608) 231-3430

### Privacy Notice Acknowledgement & Communication Authorization

Patient's Name: \_\_\_\_\_

My signature on this form acknowledges that I have reviewed a copy of John S. Rogerson M.D., Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be disclosed by John S. Rogerson M.D., and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

*I hereby give permission* to the office of John S. Rogerson, M.D., to leave messages regarding medical matters on my answering machine at telephone number (\_\_\_\_\_) \_\_\_\_\_ if I am not available at the time of return call.

Yes       No

*I hereby give permission* to the office of John S. Rogerson M.D., to convey medical information regarding my condition to my spouse, significant other, or close family member or friend as noted below if I am not available at the time of return call.

Name \_\_\_\_\_

Relationship \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Yes       No

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient's representative if patient is unable to sign

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**To Be Completed by Admitting Clinician if Form is Not Signed.**

Was the patient provided information on "where to review" the Notice of Privacy Practices?  Yes  No

Briefly describe the efforts made to obtain the patient's acknowledgement of reviewing the Notice and explain why.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**JOHN S. ROGERSON, M.D.**  
**DONALD L. WACKWITZ, M.D.**

2 Science Court, Madison, WI 53711 Tele:608-231-3410 Fax:608-231-3430 www.orthoteam.com

**Medical History Questionnaire:**

Date: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Insurance \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_

Chief Complaint: \_\_\_\_\_  
 Duration of symptoms: \_\_\_\_\_ Severity:(scale 1-10 with 10 being most severe) \_\_\_\_\_

Timing:(when does pain occur?) \_\_\_\_\_ Associated symptoms: \_\_\_\_\_

Modifying factors(what makes symptom better or worse) \_\_\_\_\_

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:**

Respiratory/Breathing Problem	Y/N	Nerve Disorders	Y/N
Asthma	Y/N	Mental health problems	Y/N
Lung Disease	Y/N	Depression	Y/N
Heart Disease	Y/N	Diabetes:Type I/ II	Y/N
Chest Pain	Y/N	Seizures	Y/N
High Blood Pressure	Y/N	Stroke	Y/N
Heart Murmur	Y/N	Cancer-type _____	Y/N
Blood Disorder/Bleeding Problem	Y/N	Hepatitis	Y/N
Severe Anemia	Y/N	Liver Disease	Y/N
Blood Clot	Y/N	Skin Disease/Cancer	Y/N
Urinary Disorders/Infection	Y/N	Arthritis	Y/N
Kidney Disease	Y/N	Rheumatoid	Y/N
Stomach Disorder	Y/N	Eye Disease	Y/N
Ulcer -Date _____	Y/N	Lupus	Y/N
Genital Problem/Disease	Y/N	Amyloidosis	Y/N

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN (Date and Treating M.D.)

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HAVE YOU EVER HAD PROBLEMS WITH ANESTHESIA?

(explain) \_\_\_\_\_

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES:

(include date/location)

MEDICATIONS(include non-prescription and herbals)

ALLERGIES TO MEDICATION/FOOD/ENVIRONMENT:

(explain) \_\_\_\_\_

ALLERGY TO METAL: Y/N

HISTORY OF MRSA/MSSA: Y/N

**SOCIAL HISTORY:**

Marital status:  Single  Married  Separated  Divorced  Widow

Alcohol use:  Never  Rarely  Moderate  Daily

Tobacco use:  Never  Rarely  Moderate  Daily

Illicit Drug use:  Never  Rarely  Moderate  Daily

**FAMILY HISTORY:**

	AGE	DISEASE	IF DECEASED, CAUSE OF DEATH
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____