OrthoMichigan
"Muscle, Bone & Joint Experts"

TODAY'S DATE: ___________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ON BOTH SIDES OF THIS FORM

NAME: ________________________________ **DATE OF BIRTH:** ________________

REFERRING PHYSICIAN: ____________________ **FAMILY DOCTOR:** ____________________

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS: IDENTIFY LOCATION AND DESCRIBE THE PROBLEM

PRIMARY COMPLAINT: ____

ON WHAT DATE DID YOU FIRST NOTICE THE PROBLEM?:________________________________

ON A SCALE OF 1-10, 10 BEING THE MOST SEVERE, CIRCLE THE NUMBER THAT BEST DESCRIBES THE PROBLEM.

1 2 3 4 5 6 7 8 9 10

WHAT MAKES THE PROBLEM WORSE (i.e. walking or squatting):______________________________

WHAT MAKES THE PROBLEM BETTER (i.e. pain meds, rest, ice, heat):__________________________

DOES IT INTERFERE WITH YOUR NORMAL DAILY ROUTINE? ☐YES ☐ NO IF YES, EXPLAIN:________________

____

WAS THIS AN INJURY? ☐ NO ☐ YES IF YES, EXPLAIN HOW THE INJURY OR PROBLEM OCCURRED: __________

____

LAWSUIT FILED? ☐ NO ☐ YES

PAST MEDICAL AND SURGICAL HISTORY *(Please select all those that apply to you)*

☐ NONE ☐ HIGH BLOOD PRESSURE ☐ HIGH CHOLESTEROL ☐ HEART DISEASE ☐ HEART BYPASS
☐ PERIPHERAL VASCULAR DISEASE ☐ STENT ☐ CONGESTIVE HEART FAILURE ☐ CARDIAC VALVE
☐ HEART ATTACK – WHEN:_____________ ☐ PACEMAKER ☐ BLOOD CLOT ☐BLEEDING DISORDER ☐ CANCER
☐ DIABETES ☐ HEPATITIS ☐ DIALYSIS ☐ KIDNEY FAILURE ☐ KIDNEY (RENAL) DISEASE
☐ LIVER DISEASE ☐ STROKE ☐HEMIPLEGIA/PARAPLEGIA ☐ CEREBROVASCULAR DISEASE ☐ DEMENTIA
☐ COPD ☐ ASTHMA ☐ RHEUMATOID DISEASE ☐ AIDS/HIV ☐ COVID-19
☐ OSTEOPOROSIS ☐ ARTHRITIS ☐ DEPRESSION/ANXIETY ☐ OTHER ________________________

ALLERGIES				**SOCIAL HISTORY**		
DRUG	**ANESTHETICS**	**FOOD**	**OTHER**	**Y**	**N**	
☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**			Do you smoke? If yes, # of packs/day:
						Do you drink? If yes, # of drinks/day:
						Marijuana? ☐ Smoke ☐ Other

ALLERGY TO ANY OF THE FOLLOWING: ☐ **LATEX** ☐ **METAL** ☐ **CONTRAST DYE** ☐ **BARIUM** ☐ **TAPE**

DO YOU SEE A CARDIOLOGIST? ☐ NO ☐ YES NAME: ____
DO YOU SEE A PULMONOLOGIST? ☐ NO ☐ YES NAME: ____
DO YOU SEE A NEPHROLOGIST? ☐ NO ☐ YES NAME: ____

HAVE YOU EVER RECEIVED A PNEUMONIA VACCINE?: ☐ NO ☐ YES
HAVE YOU RECEIVED A FLU SHOT WITHIN THE LAST 12 MONTHS?: ☐ NO ☐ YES
HAVE YOU RECEIVED THE COVID-19 VACCINE?: ☐ NO ☐ YES

Height:

Weight:

MEDICATION(S): *(Please list your current medications)*

PAST SURGICAL HISTORY: *(Please list your surgeries)*

FAMILY HISTORY: *(Serious illness for example bleeding, blood clot, heart attack)*

FATHER	
MOTHER	
BROTHERS	
SISTERS	

Patient Signature: ________________________________

Date: ________________

I have reviewed this patient history form.

Physician Signature: ________________________________

Date: ________________