OrthoMichigan

A. George Dass, M.D.
David A. Fernandez, M.D.
Andrew R. Fras, M.D.
Matthew W. Hettle, M.D.
Sidney N. Martin, M.D.
Gordon A. McClimans II, D.O.
Susan Mosier-LaClair, M.D.
Charles K. Safley, M.D.
Matthew C. Sardelli, M.D.
Ajay K. Srivastava, M.D.
Paul M. Telehowski, M.D.
Norman E. Walter, M.D.
Seann E. Willson, M.D.
John J. L. Yap, M.D.

Joint Replacement • Sports Medicine • Spine • Knee • Hand/Upper Extremity • Foot/Ankle

Flint Office: 4466 West Bristol Road • Flint, Michigan 48507 • Ph: (810) 733-1200 • Fax: (810) 733-0688 • Billing: (810) 733-3990
Lapeer Office: 307 South Court Street • Lapeer, Michigan 48446 • Ph: (810) 667-6110 • Fax: (810) 667-3917
Fenton Office: 17015 Silver Parkway • Fenton, Michigan 48430 • Ph: (810) 593-0023 • Fax: (810) 593-0201

Dear Patient:

Enclosed you will find a back history packet. In order to treat your problem efficiently, we request that these forms be filled out completely prior to your appointment. Thank you for your cooperation.

You will need to obtain ***ALL*** prior spine x-rays, myelograms, CT scans, MRIs and a copy of all reports. Please bring these together with any MEDICAL RECORDS (EMGs, office notes, test results, etc.) with you the day of your appointment.

Thank you

OrthoMichigan

Name: _____ **Date:** _____

OCCUPATION: _____ **REFERRED BY:** _____

CHIEF COMPLAINT: Part(s) of body injured or painful: _____
_____
_____

HISTORY OF INJURY:
Exact date of injury/painful event: _____
City/State where injury occurred: _____
Work related injury? YES/NO: _____
Employer's Name/Location on injury date: _____
Describe in detail how injury occurred: _____
Describe your pain/problems **IMMEDIATELY** (48 hours) following injury: _____
_____
_____
Describe the **INITIAL** treatment you received (dates and physician's names, medications, physical therapy, etc.):
_____
_____
_____

HISTORY OF CHONIC PAIN/PROBLEMS:
Date when you first noticed pain/problem: _____
Describe the progression of pain/problem (dates of changes in your status, surgeries, other events): _____
_____
_____
Has there been any pain free intervals with physical therapy or after surgery?: _____

CURRENT TREATMENTS (therapy, medication, braces, etc.):
Physical therapy (type/location): _____
Anti-inflammatories: _____
Pain killers: _____
Muscle relaxers: _____
Sleeping pills: _____
List all special tests and results prior to this evaluation (include dates, location, and any hospitalizations): _____
_____
_____
_____
Names/Locations of physicians who have evaluated/treated you: _____
_____
_____
_____

WORK STATUS: Have you missed time from work because of INJURY/PAIN/ PROBLEM? List dates: _____
_____
Have you returned to modified work or changed jobs? Explain: _____
Have you had previous injuries or treatment to any part(s) of your body for which you now seek our help? YES/NO
Please explain: _____
Have you had any subsequent injuries or exacerbations of pain since you initial claim? Explain: _____
_____
_____

DO YOU HAVE AN ATTORNEY INVOLVED WITH YOUR CASE? YES / NO (Their name and address)

_____

_____

_____

REVIEW OF OUTSIDE MEDICAL RECORDS: (For doctor use only)

_____

_____

_____

_____

CURRENT SYMPTOMS:

Describe in DETAIL your PRESENT complaints and symptoms: _____

_____

_____

_____

_____

_____

_____

Number of hours you can sit:_____, stand: _____, walk: _____

How far can you walk? _____# blocks/miles_____

Is your pain exactly like it was during initial weeks/months from injury? _____

Has there been a pain free interval with rest, physical therapy, and/or surgery? _____

Where do you hurt the MOST? _____

My pain is: (please circle) { dull / sharp / achy / cramping } { stabbing / throbbing / burning }

Other: _____

Do you have: { numbness / tingling } Where? _____

Does the pain/numbness travel? YES / NO Where? _____

MY PAIN is:	BETTER	WORSE	SAME
With cough/sneeze/straining	_____	_____	_____
Sitting	_____	_____	_____
Standing	_____	_____	_____
Walking	_____	_____	_____
Lifting	_____	_____	_____
Bending Forward	_____	_____	_____
Bending Backward	_____	_____	_____
Walking up/down stairs	_____	_____	_____
When I get up in morning	_____	_____	_____
Midday	_____	_____	_____
Middle of the night	_____	_____	_____
Lying flat on back	_____	_____	_____
Lying on stomach	_____	_____	_____
Lying on side with knees bent	_____	_____	_____

Since the injury/time I noticed the problem, my pain has become (worse / better / remained the same)

Please comment: _____

Do you have problems with sleep? _____

Are there recent changes in bowel / bladder habits? _____

Are you experiencing any sexual difficulties? _____

Headaches / vision changes / hearing changes / balance problems? _____

PAST MEDICAL HISTORY:

Circle if you now have or have previously suffered from (please list dates and explain):
High blood pressure / Heart attack / Lung problems / Thyroid condition / Liver disease / Ulcers /
Diabetes / Seizures / Strokes / Blood clots / Mental illness / Arthritis / Blood transfusion /
Other: _____

Last menstrual period: _____

Previous surgeries (type of operations and dates/name of physician): _____

_____

_____

Any other hospitalizations (reason and dates): _____

_____

_____

Allergies (medicines, foods, pollens, etc.): Please list and describe effects on you: _____

_____

Medications (and their dose) other than those previously listed: _____

_____

_____

REVIEW OF SYSTEMS: (Please check if applicable)

NEUROLOGICAL:
_____ loss of consciousness
_____ paralysis
_____ changes in taste/smell
_____ tremors
_____ gait disturbances
_____ headaches

CARDIOVASCULAR:
_____ shortness of breath
_____ palpitations
_____ chest pain on exertion
_____ resting chest pain
_____ leg swelling
_____ leg pain at night / rest

MUSCULOSKELETAL:
_____ backache
_____ neckache
_____ stiffness
_____ fractures
_____ joint swelling
_____ muscle weakness
_____ muscle cramps
_____ leg pain with walking

RESPIRATORY:
_____ chronic cough
_____ wheezing / asthma
_____ pain with breathing
_____ flu / pneumonia

GASTROINTESTINAL:
_____ swallowing difficulty
_____ heartburn
_____ nausea / vomiting
_____ abdominal pain
_____ ulcer
_____ jaundice / hepatitis
_____ blood in stool
_____ weight loss / gain

GENITOURINARY:
_____ urinary frequency / urgency
_____ inability to urinate
_____ dribbling
_____ increased amount of urine
_____ stones
_____ discharge / venereal disease
_____ pelvis pain
_____ painful intercourse

FAMILY HISTORY:	LIVING	DECEASED	CAUSE OF DEATH	AGE
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____

Please mark the following found in family:

	Mother	Father	Sister	Brother	Child
Diabetes	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____

SOCIAL HISTORY:

Occupation: _____ Currently working? YES / NO
Date you last worked: _____
Activity limitations: _____

Marital Status: Married / Single / Divorced / Widowed
Number of children: _____ Ages: _____ Number living at home: _____

Education completed (years): 9 10 11 12 13 14 15 16 16+

Alcohol use: _____ beers/drinks per day / week (circle)
Tobacco use: _____ packs per day for _____ years

Name and address of your family physician: _____
_____
_____

AN IMPORTANT REMINDER:

You will need to obtain **ALL** prior spine x-rays, myelograms, CAT scans, spine MRI scans, and a copy of their reports by the radiologist. **PLEASE BRING THESE** together with any **MEDICAL RECORDS** of pertinent examinations (i.e. EMG, prior physician evaluations) with you the day of your appointment.

On the day of your examination you will undergo a complete orthopedic spine evaluation by the primary physician and members of his staff. The assessment along with your x-rays and other tests will be compiled into a detailed report for your insurance carrier. We feel your spine problems deserve this careful attention to obtain an accurate diagnosis and help initiate the appropriate treatment. Your cooperation with our procedures will help to ensure our continued medical intervention towards you spinal condition.

_____
Signature

Name: _____ **Date:** _____

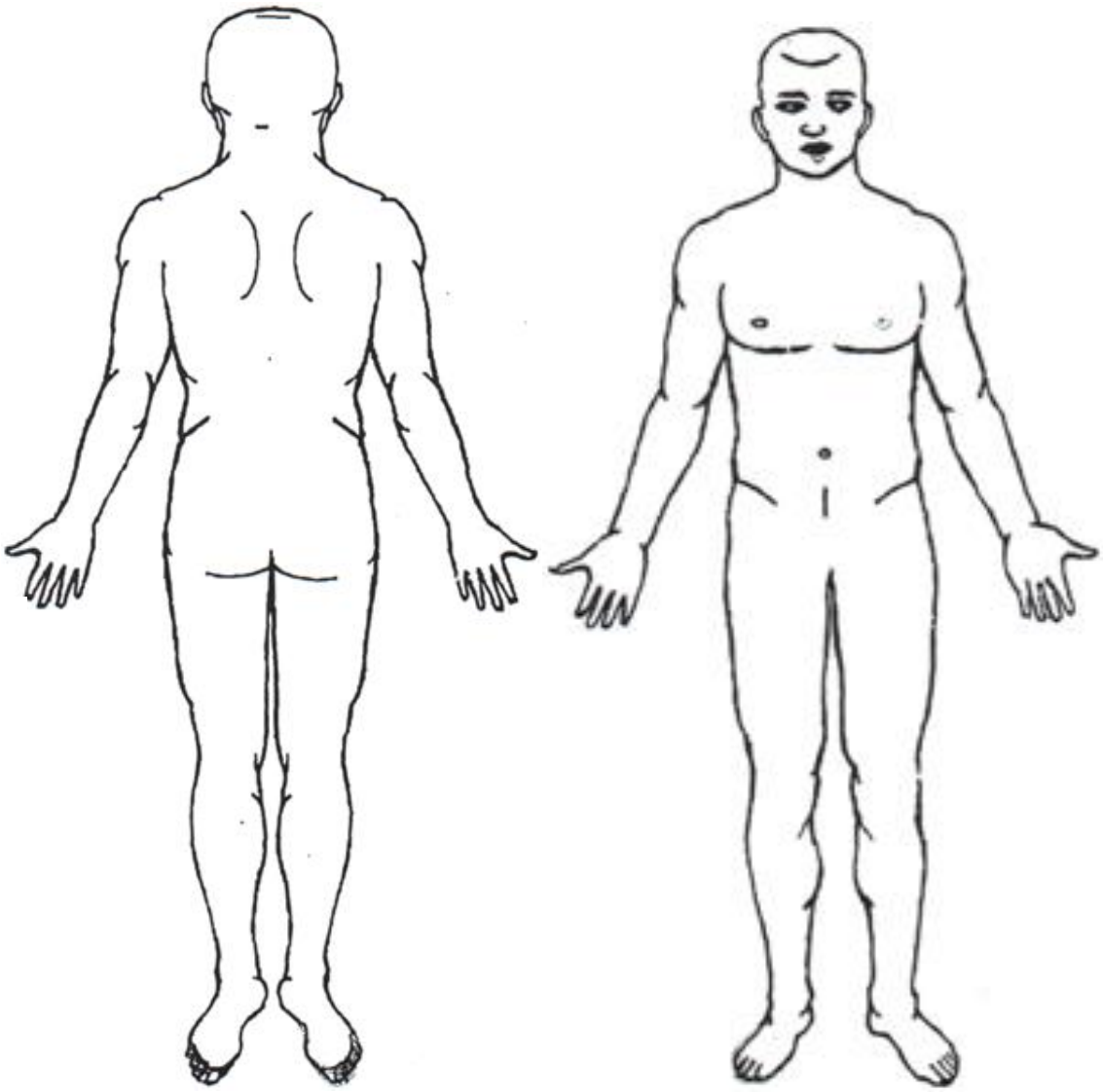
PATIENT PAIN DRAWING

Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas where sensations travel, if any. Include **ALL** affected areas.

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
>>>>>	==========	00000	xxxxx	//////
>>>>>	==========	00000	xxxxx	//////

Pain in arms(s) compared to neck
Worse than:
Same as:
Less than:

BACK **FRONT**



Left **Left**