PATIENT HISTORY FORM

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

NAME:_____ DATE OF BIRTH:_____

REFERRING PHYSICIAN:_____ TODAY'S DATE:_____

CHIEF COMPLAINT

DATE OF INJURY:_____ WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL)_____

_____

_____

FOR THIS PROBLEM/INJURY HAVE YOU HAD AN X-RAY,CT, MRI, EMG OR BLOOD WORK? (CIRCLE ANY)

WHEN & WHERE:_____

HISTORY OF PRESENT ILLNESS

LOCATION OF THE PROBLEM

BACK SHOULDER NECK KNEE ANKLE

HEAD HIP WRIST HAND ELBOW

OTHER:_____

_____

ON A SCALE OF 1- 10, WITH 10 BEING THE MOST SEVERE, CIRCLE

1 2 3 4 5 6 7 8 9 10

WHEN DID YOU FIRST NOTICE THE PROBLEM?_____

_____DAYS AGO _____WEEKS AGO _____MONTHS AGO

OTHER:_____

HOW LONG DOES THIS PROBLEM LAST?_____

_____MINUTES _____HOURS _____ALWAYS THERE

OTHER:_____

DOES ANYTHING MAKE THE PROBLEM WORSE? Y N

_____

_____

DOES ANYTHING MAKE THE PROBLEM BETTER? Y N

_____

IS ANYTHING OCCURRING AT THE SAME TIME? Y N

IF YES PLEASE EXPLAIN_____

_____

IS THE PROBLEM CONSTANT OR VARIABLE? Y N

IF YES, PLEASE EXPLAIN_____

_____

DOES IT INTERFERE WITH YOUR NORMAL DAILY ROUTINE?

Y N IF YES PLEASE EXPLAIN_____

_____

PAST MEDICAL, FAMILY & SOCIAL HISTORY

ALLERGIES **NO** (CIRCLE ONE) **YES** (IF YES PLEASE LIST)	**Y**	**N**	**SOCIAL HISTORY**
DRUGS (INCLUDING ANESTHETICS) /FOOD/OTHER			DO YOU SMOKE? IF YES, #PACKS/DAY:
			DO YOU DRINK? IF YES # DRINKS/DAY:
			DO YOU USE STREET DRUGS?
			ARE YOU ON ANY SPECIAL DIETS?
			ARE YOU ON ANY FOOD RESTRICTIONS?
	SPECIFY:		

PLEASE LIST ALL CHRONIC OR SERIOUS ILLNESSES BELOW:		**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY ON BELOW:**	

PAST SURGERIES/HOSPITALIZATIONS OR ACCIDENTS **( ) NONE**	**REASON & DATE**

FAMILY HISTORY	**CURRENT AGE**	**AGE AT DEATH**	**SERIOUS ILLNESSES** (EXAMPLES: DIABETES, CANCER, HEART, KIDNEY, ALCOHOL, HIGH BLOOD PRESSURE, ACCIDENTS, ETC)
FATHER			
MOTHER			
BROTHERS			
SISTERS			

REVIEW OF SYSTEMS

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING?
(CIRCLE YES OR NO AND PLEASE EXPLAIN ANY YES ANSWERS IN THE SPACE PROVIDED.)

CONSTITUTIONAL SYMPTOMS			**INTEGUMENTARY**		
FEVER	Y	N	SKIN RASH	Y	N
CHILLS	Y	N	BOILS	Y	N
HEADACHES	Y	N	PERSISTENT ITCH	Y	N
OTHER			OTHER		
EYES			**MUSCULOSKELETAL**		
BLURRED VISION	Y	N	JOINT PAIN	Y	N
DOUBLE VISION	Y	N	NECK PAIN	Y	N
PAIN	Y	N	BACK PAIN	Y	N
OTHER			OTHER		
ALLERGIC/IMMUNOLOGIC			**EARS/NOSE/THROAT/MOUTH**		
HAYFEVER	Y	N	EAR INFECTION	Y	N
DRUG ALLERGIES	Y	N	SORE THROAT	Y	N
			SINUS PROBLEM	Y	N
OTHER			OTHER		
NEUROLOGICAL			**GENITOURINARY**		
TREMORS	Y	N	URINE RETENTION	Y	N
DIZZY SPELLS	Y	N	PAINFUL URINATION	Y	N
NUMBNESS/TINGLING	Y	N	URINARY FREQUENCY	Y	N
OTHER			OTHER		
ENDOCRINE			**RESPIRATORY**		
EXCESSIVE THIRST	Y	N	WHEEZING	Y	N
TOO HOT/COLD	Y	N	FREQUENT COUGH	Y	N
TIRED/SLUGGISH	Y	N	SHORTNESS OF BREATH	Y	N
OTHER			OTHER		
GASTROINTESTINAL			**HEMATOLOGIC/LYMPHATIC**		
ABDOMINAL PAIN	Y	N	SWOLLEN GLANDS	Y	N
NAUSEA/VOMITING	Y	N	BLOOD CLOTTING PROBLEM	Y	N
INDIGESTION/HEARTBURN	Y	N			
OTHER			OTHER		
CARDIOVASCULAR			**PSYCHOLOGIC**		
CHEST PAIN	Y	N	ARE YOU GENERALLY SATISFIED WITH YOUR LIFE?	Y	N
VARICOSE VEINS	Y	N	DO YOU FEEL SEVERELY DEPRESSED?	Y	N
HIGH BLOOD PRESSURE	Y	N	HAVE YOU CONSIDERED SUICIDE?	Y	N
OTHER			OTHER		

PHYSICIAN SIGNATURE:_____ DATE:_____

AMJAD YAISH, D.O. MICHAEL WAGNER, D.O.

MACOMB ORTHOPEDICS
38525 HILLDALE ST.
CLINTON TWP., MI 48036

PLEASE PRINT & FILL OUT COMPLETELY

PATIENT NAME:_____ BIRTHDATE:_____
LAST FIRST MI

ADDRESS:_____CITY:_____STATE____ ZIP_____

PHONE: (_____)_____ CELL PHONE: (_____)_____

AGE:_____ SEX: M F MARITAL STATUS: S M W D SOCIAL SECURITY#:_____
(CIRCLE ONE) (CIRCLE ONE)

EMPLOYER:_____ WORK PHONE#:(_____)_____

REFERRING/FAMILY DOCTOR:_____

REFERRING/FAMILY DOCTOR PHONE NUMBER: (_____)_____

EMERGENCY CONTACT: _____PHONE (_____)_____

(IF RESPONSIBLE PERSON IS OTHER THAN PATIENT, PLEASE COMPLETE THE FOLLOWING INFORMATION ABOUT THEM)

NAME:_____SSN#:_____DOB:_____

ADDRESS (IF DIFFERENT FROM PATIENT):_____

CITY:_____ STATE:_____ ZIP:_____ PHONE:(____)_____

RELATIONSHIP TO PATIENT:_____ EMPLOYER:_____

WORK PHONE (____)_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____PHONE: _____EFFECTIVE DATE:_____

POLICY CONTRACT ID#_____GROUP_____COVERAGE/PLAN CODE_____

SUBSCRIBER NAME:_____ DOB:_____

EMPLOYER:_____SS# FOR SUBSCRIBER:_____

IS THIS AN AUTO INJURY ? (CIRCLE) YES NO ……WORKERS COMPENSATION ? (CIRCLE) YES NO

*****IF THIS IS AUTO OR WORKER'S COMP RELATED PLEASE FILL OUT THE BACK OF THIS FORM*****

PLEASE PRESENT YOUR INSURANCE CARD(S) AND PHOTO ID TO US UPON COMPLETE OF THIS FORM.

I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required to my insurance company, referring doctor or family doctor. Payments for co-pays and co-insurance amounts are expected at the time services are rendered.

PATIENT SIGNATURE:_____ DATE:_____
(OR RESPONSIBLE PERSON)

WORKER'S COMPENSATION CLAIM

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____
STREET CITY STATE ZIP

TELEPHONE #: (___) _____ CONTACT PERSON:_____

WORK COMP CARRIER (INS. CO):_____

ADDRESS:_____
STREET CITY STATE ZIP

CLAIM#:_____ CONTACT PERSON:_____

CONTACT PERSON PHONE NUMBER:_____

WHAT IS THE DOCTOR SEEING YOU FOR?_____

_____

HOW DID IT HAPPEN?_____

_____

DATE OF INJURY:_____ HAS YOUR EMPLOYER BEEN NOTIFIED? YES____ NO _____

CAN WE OBTAIN A COPY FOR OUR FILES? YES_____ NO _____

IS THIS CASE IN DISPUTE ? YES____ NO _____

HAS YOUR EMPLOYER OR WORK COMP CARRIER AUTHORIZED YOU TO SEE US ? YES_____ NO _____

DO YOU HAVE AN ATTORNEY ? YES_____ NO _____ IF YES PLEASE SUPPLY THE FOLLOWING:

ATTORNEY'S NAME:_____ TELEPHONE: (____) _____

Please make sure the other side of this form is filled out completely.

Thank you.