

Name:
DOB:
Age:
Chart:

Date:

Orthopaedic Surgery Associates

O F M A R Q U E T T E P C

www.upbonedoctors.com

Office: 906-225-1321 Business Fax: 906-228-9371 Clinic Fax: 906-225-3968

Name _____ Date _____

Address _____ Telephone _____

City / State / Zip _____

Occupation _____

(or Retired Occupation) Date Retired _____

Date of Birth _____ Height Ft _____ In _____ Weight _____

Years of School _____ Religion _____

Primary Care (Physician) Provider _____

Who else have you seen for this condition? _____

Are you claiming this as a work-related injury (workman's comp)? yes no

Is there litigation pending or contemplated regarding this condition? yes no

Describe When / Where / How your pain started _____

Describe location of pain _____

Describe the pain Sharp, knife-like Shock Burning
 Radiating Dull Ache
 Other _____

Rate your pain between 1 and 10 (10 being the worst)

	Back	Neck	Leg	Arms
Pain is usually (1-10)	_____	_____	_____	_____
At its worst (1-10)	_____	_____	_____	_____

Is the pain Constant Intermittent With Activity
 Other _____

Does this pain Keep you awake at night Wake you out of a sound sleep
 Other _____

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- Do you have any loss of Bladder Function Bowel Function
- Does the following make this pain worse sneezing coughing
- Does the pain shoot down your leg no yes, which leg..... R L
- Does the pain radiate to your buttock calf thigh feet
- Do you have numbness or tingling in your leg(s) no yes, which leg..... R L
- Is pain resolved with sitting yes no
- Is pain relieved with bending forward yes no

Have you had any of the following treatments

- | | | |
|--|--|---|
| <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Biofeedback |
| <input type="checkbox"/> Bed Rest | <input type="checkbox"/> Traction | <input type="checkbox"/> Heat Therapy |
| <input type="checkbox"/> Chiropractic Treatment | <input type="checkbox"/> Osteopathic Treatment | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Tens (Electrical Stimulation) | <input type="checkbox"/> Psychotherapy / Psychiatric | <input type="checkbox"/> Steroid Injections |
| <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Medications _____ | | |

Indicate when and where if you have had the following exams

Exams	Date	Where
X-Rays	_____	_____
Myelogram	_____	_____
Cat Scan	_____	_____
Bone Scan	_____	_____
MRI	_____	_____
EMG	_____	_____
EKG	_____	_____
Lab Work	_____	_____

Name: _____

DOB: _____

Age: _____

Chart: _____

Date: _____

Past Medical History _____

List all previous surgeries

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Allergies _____

Physician Prescribed Medications _____

Over the Counter Drugs / Herbs _____

Family History

Back Pain

Cancer

Heart Attack

High Blood Pressure

Diabetes

Stroke

Does back pain run in the family yes no

Does neck pain run in the family yes no

Number of close relatives with back surgery _____

Number of close relatives with neck surgery _____

Marital Status M S D W

Number of children _____

Social History Smoking packs / day _____ Quit when _____ Alcohol oz / week _____

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Do you have any of the following

Orthopaedic Problems

Numbness / Tingling Sensation

Arthritis / Rheumatism

Back Pain

Bone Fracture

Foot Pain / Cold Numb Feet

Gout

Muscle Weakness

Joint Pain

Decreased Hearing

Ringing in Ears

Ear Infections - Frequent

Dizzy Spells

Failing Vision

Double or Blurred Vision

Nose Bleeds - Frequent

Sinus Trouble

Sore Throat - Frequent

Pneumonia / Pleurisy

Bronchitis / Chronic Cough

Asthma / Wheezing

Short of Breath

On Exertion

Lying Flat

Chest Pain

High Blood Pressure

Heart Murmur

Palpitations

Irregular Pulse

Heart Attack

Fainting Spells

Swollen Ankles

Leg Pain When Walking

Varicose Veins / Phlebitis

Loss of Appetite - Recent

Indigestion or Heartburn

Bloody or Tarry Stools

Hemorrhoids

Jaundice / Hepatitis

Urinary Infections - Frequent

Kidney Stones / Disease

Venereal /

Sexually Transmitted Disease

Chronic Fatigue

Weight Loss - Recent

Anemia

Bleed Easily

Cancer

Diabetes

Convulsions

Stroke

Psoriasis / Eczema

Depression

Memory Loss

Phobias

Mental Illness

Headaches - Frequent

Tuberculosis

Glaucoma

Slow Healer

History of Lyme's Disease

Patient Name:

Print Name

Patient Signature:
