ORTHOPAEDIC SURGERY ASSOCIATES OF MARQUETTE, P.C.
1414 West Fair Avenue, Suite 190 • Marquette, Michigan 49855
Matthew B. Colligan, D.O.

HISTORY QUESTIONNAIRE

Please fill out these forms and bring them to your appointment scheduled with Dr. Matthew Colligan, D.O.

Appointment Date: ____________________ **Time:** ____________

1-800-462-6367 (906) 225-1321

ORTHOPAEDIC SURGERY ASSOCIATES OF MARQUETTE, P.C.

KENNETH A. DAVENPORT, M.D.
MATTHEW N. SONGER, M.D.
WALLACE G. PEARSON, II, M.D.
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MATTHEW B. COLLIGAN, D.O.
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1414 WEST FAIR AVENUE, SUITE 190
UPPER PENINSULA MEDICAL CENTER
MARQUETTE, MICHIGAN 49855

(906) 225-1321 APPOINTMENTS
(906) 228-7020 BUSINESS OFFICE
(906) 228-9371 FAX NUMBER
1-800-462-6367 WATS NUMBER

PATIENT QUESTIONNAIRE
INITIAL EVALUATION

Date: ______________________________

Patient Name: ______________________ (Office use only) MR # ______________

Family/Primary Doctor: ______________________ Phone: ______________

____

Who referred you to Orthopaedic Surgery Associates of Marquette, P.C. (name & address please)? ______________

____

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. ***Circle the word or phrase that best describes your situation. You may select more than one answer per question.*** Answer the question in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. **THANK YOU.**

Age: __________ Sex: __________ Marital Status: __________ Handed: R/L ______

Height: __________ Weight: __________

Occupation: ______________________________

What are you seeing the doctor for? ______________________________

Duration of Symptoms: ______________________________

When did the problem first start or when did the injury occur? ______________

Is this injury work related? Yes / No

Have you seen a doctor in the past for this problem or injury? Yes / No If yes, who and when? ______________

____

Explain in your own words how this injury occurred: ______________________________

____

____

____

What treatment have you had? ______________________________

____

____

____

Would you be interested in taking part in a research study? Yes / No

TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:

Circle anything listed below to which you are allergic:

(A) No known allergies
(B) Penicillin
(C) Tetracycline
(D) Sulfa
(E) Morphine
(F) Erythromycin
(G) Codeine
(H) Iodine/Betadine
(I) Radiographic Dyes
(J) Adhesive Tape
(K) Other (Specify): ____________________

Circle any of the medical problems listed below that you have now:

(A) I have no known medical problems.
(B) Hypertension
(C) Coronary artery disease
(D) Peripheral vascular disease
(E) Adult onset diabetes
(F) Childhood onset diabetes
(G) Past heart attack
(H) Asthma
(I) Ulcers
(J) Hepatitis A / B / C
(K) Cancer
(L) Tuberculosis
(M) Liver disease
(N) Seizure disorder
(O) Thyroid disease
(P) Emphysema
(Q) COPD/Lung problem
(R) Immune disorder
(S) Overweight
(T) Osteomyelitis
(U) Blood Clot (DVT)
(V) Osteoporosis
(W) Other (Specify): ____________________

____

How much alcohol do you consume?

(A) I'm a non-drinker
(B) I'm a recovering alcoholic
(C) I drink only occasionally
(D) I drink weekends only
(E) An average of 1-2 drinks per day
(F) An average of 2-3 drinks per day
(G) An average of 3-4 drinks per day
(H) More than 6 drinks a day

Do you now, or have you ever smoked cigarettes?

(A) Yes, I am currently a smoker
I smoke (circle one) 1 2 3 ____________ packs/day
I have smoked for ____________ years
(B) No, but I used to smoke I smoked for ____________ years
(C) No, I have never smoked

Do you now, or have you ever used drugs?

(A) Recreational
(B) Cocaine
(C) Marijuana
(D) Other (Specify): ____________________

Has anyone in your immediate family ever had any of the following? Circle the illness that apply.

(A) None known
(B) Cancer
(C) Leukemia
(D) Stroke
(E) Hypertension
(F) Coronary artery disease
(G) Rheumatic fever
(H) Diabetes
(I) Hypothyroidism
(J) Colitis
(K) Bleeding tendency
(L) Asthma
(M) Tuberculosis
(N) Seizure disorder
(O) Alcoholism
(P) Other (Specify): ____________________

Have you ever had a blood clot? Yes No

Circle any surgeries listed below you may have had. Indicate the year of the surgery:

(A)	No previous surgeries	(G)	Hysterectomy ______
(B)	Appendectomy ______	(H)	Lumber laminectomy ______
(C)	Cataract extraction ______	(I)	Mastectomy ______
(D)	By-pass / open heart ______	(J)	Tonsillectomy ______
(E)	Gall bladder ______	(K)	Prostate surgery ______
(F)	Hernia repair ______	(L)	Other (Specify): ______

Any previous broken bones: ______

Blood transfusion: Yes / No Year: ______

What medications are you currently taking? Please include both prescription and non-prescription medications.

Medications	Dose	# Times a Day

Please circle any anti-inflammatory medications listed below which you have taken in the past. Please include all prescription and non-prescription medication and samples, which were provided.

Advil Arthrotec Daypro Ibuprofen Lodine Naprelan Naproxen

Oruvail Tylenol Ultram Other: ______

Please circle any of the following side effects while you were currently taking any of the above anti-inflammatory medications.

Nausea Diarrhea Gastric Ulcers Upset stomach Vomiting

Other: ______

Are you currently taking any of the following on a regular basis?

Aspirin Axid Coumadin Cytotec Heparin Maalox Mylanta

Pepcid Prevacid Prilosec Tagamet Zantac

TELL US ABOUT YOUR HEALTH IN GENERAL: Do you have any of the following? Circle YES or NO.

SYMPTOMS			COMMENTS
Chest Pain	Yes	No	
Dizziness	Yes	No	
Dry cough	Yes	No	
Productive cough	Yes	No	
Difficulty breathing	Yes	No	
Irregular heartbeat	Yes	No	
Swelling in the legs	Yes	No	
Lack of appetite	Yes	No	
Nausea	Yes	No	
Vomiting	Yes	No	
Diarrhea	Yes	No	
Constipation	Yes	No	
Abdominal cramping	Yes	No	
Varicose veins	Yes	No	
Bruising	Yes	No	
Bleeding	Yes	No	
Nose bleeds	Yes	No	
Joint pain and/or stiffness	Yes	No	
Muscle pain or muscle cramps	Yes	No	
Difficulty seeing	Yes	No	
Difficulty hearing	Yes	No	
Difficulty swallowing	Yes	No	
Difficulty sleeping	Yes	No	

Everything I have answered is true and correct to the best of my knowledge.

____

Patient Signature

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.
IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD

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