Name:
DOB:
Chart:
Age:
Date:

WELCOME TO GREAT LAKES ORTHOPAEDICS

Patient Name: _____ (First) _____ (Middle) _____ (Last)

Address: _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____ SSN #: _____

Sex: _____ Marital Status ☐ M ☐ S ☐ W ☐ D DOB: _____ Age _____ Weight _____ Height _____

Emergency Contact Name _____ Emergency Contact Number _____ Emergency Contact Relation _____

Race Choices: ☐ Declined Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific ☐ White

Ethnicity Choices: ☐ Declined Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Language: _____ ☐ Declined Language

Occupation _____ Employer's Name _____

Employer's Name and Address _____

City _____ State _____ Zip _____ Employer's Phone: _____

Family Doctor: _____ Family Doctor's Phone: _____

Referring Doctor: _____ Referring Doctor's Phone: _____

Referring Doctor's Address: _____ City _____ State _____ Zip _____

Appointment Information

What are we seeing you for today? Include body part and date symptoms began: _____

Did you injure yourself? _____ Date of Injury _____ Date symptoms began _____

Explain in detail how your problem started _____

Where? Work Injury _____ Automobile Injury? _____ Did you report your injury? _____

Do you have an attorney? _____ Name _____ Phone _____

Primary Insurance

Insurance Name: _____ Subscribers' Employer _____

Policy/Contract No. _____ Subscribers' Birth date _____

Group No. _____ Subscribers' SS No. _____

Subscribers' Name _____ Subscribers' Daytime Phone _____

Relationship to Patient _____

Secondary Insurance

Insurance Name: _____ Subscribers' Employer _____

Policy/Contract No. _____ Subscribers" Birth date _____

Group No. _____ Subscribers' SS No. _____

Subscribers' Name _____ Subscribers' Daytime Phone _____

Relationship to Patient _____

Complete this section only if someone other than the patient is financially responsible.

Name _____ Relationship to Patient _____

Address _____ SS No. _____

City _____ State _____ Zip _____ Employer _____

Telephone _____ Employer Phone _____

Authorization

I represent that I have insurance coverage and do hereby authorize my carrier to pay and assign directly to Great Lakes Orthopaedics all benefits otherwise payable to me for the services described. I understand that I will be responsible for any balance not covered by insurance benefits. I authorize the release of all information regarding my condition as necessary to process these and/or related claims. I permit a copy of this to be used in the place of the original. I agree that Great Lakes Orthopaedics may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature _____ Date _____

Name:
DOB:
Chart:
Age:
Date:

Have you had any previous broken bones or orthopedic problems? ☐ Yes ☐ No
Explain _____

Blood transfusions? ☐ Yes ☐ No

Check anything listed below to which you are allergic:

☐ None ☐ Penicillin ☐ Tetracycline ☐ Sulfa ☐ Radiographic dye
☐ Erythromycin ☐ Codeine ☐ Iodine/ betadine ☐ Adhesive tape
☐ Morphine
☐ Other

Please list all medications you are currently taking. Prescription arid non prescription.

Medications	Dose	What do you take medication for?

Tell us about your health in general. Do you have any of the following? Check yes or no.

SYMPTOMS:

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 legs	☐ Yes ☐ No	Lack of appetite	☐ Yes ☐ No
Increased 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 stiffness	☐ Yes ☐ No	Muscle pain, cramps	☐ Yes ☐ No
Difficulty seeing	☐ Yes ☐ No	Difficulty swallowing	☐ Yes ☐ No
Difficulty sleeping	☐ Yes ☐ No		

Date last menstrual period _____ Any chance you are pregnant? ☐ Yes ☐ No

I have reviewed the medical history form with the patient.

_____ Date _____
Doctor's Signature

Name:
DOB:
Chart:
Age:
Date:

PATIENT HISTORY QUESTIONNAIRE

NAME: _____ Date of Birth: _____ Today's Date: _____

Check any of the medical problems listed below that you have now.

☐ I have no known medical problems.

☐ Arthritis Rheumatoid, Other
☐ Hypertension
☐ Immune disorder
☐ MS
☐ Asthma
☐ Cancer
☐ COPD/lung problem
☐ Coronary artery disease
☐ Diabetes Adult, Juvenile
☐ Emphysema
☐ Gout
☐ HIV/AIDS
☐ Hepatitis
☐ Lupus
☐ Ulcers
☐ Liver disease
☐ Osteomyelitis
☐ Overweight
☐ Past heart attack
☐ Peripheral vascular disease
☐ Seizure disorder
☐ Thyroid disease
☐ Other: _____

Are you ☐ Right handed ☐ Left handed ☐ Both

How much alcohol do you consume?
☐ I am a non drinker
☐ I am a recovering alcoholic
☐ I drink occasionally
☐ I drink weekends only

Average: ☐ 1-2 drinks per day
☐ 2-3 drinks per day
☐ 3-4 drinks per day
☐ More than 6 drinks

Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown
☐ Heavy tobacco smoker ☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked ☐ Light tobacco smoker
Current smoker ☐ 1 ☐ 2 ☐ 3 packs per day
What year I started smoking _____
What year I stopped smoking _____

Do you now or have you ever used drugs?
☐ Cocaine ☐ Marijuana ☐ Other

Has anyone in your immediate family ever had any of the following? Please Check
☐ None known
☐ Hypertension
☐ Coronary artery disease
☐ Hypothyroidism
☐ Cancer
☐ Diabetes
☐ Asthma
☐ Alcoholism
☐ Leukemia
☐ Colitis
☐ Tuberculosis
☐ Seizure disorder
☐ Stroke
☐ Rheumatic fever
☐ Bleeding tendency

Check any surgeries listed below you may have had. Indicate year of surgery.
☐ No previous surgeries.
☐ Appendectomy _____
☐ Hernia repair _____
☐ Tonsillectomy _____
☐ Hysterectomy _____
☐ Cataract extraction _____
☐ Lumbar laminectomy _____
☐ Prostate surgery _____
☐ Bypass Open heart _____
☐ Gall bladder _____
☐ Mastectomy _____
☐ Other _____