

Big Rapids Orthopaedics, PC

History Form

Name _____ Date of Birth _____ Age _____

Occupation _____

Family Physician _____

Why are you seeing the doctor today? (Describe in detail): _____

Have you had any treatment for the current problem? _____ If yes by whom: _____

Is current problem the result of a(n): Car Accident Work Accident Accident, other _____

Accident date: _____

Have you had any of the following done in relation to current problem? (Please circle all that apply):

XRAYS CT ULTRASOUND MRI EMG NERVE CONDUCTION OTHER: _____

YOU ARE RESPONSIBLE FOR OBTAINING YOUR XRAYS AND REPORTS AND BRINGING THEM TO YOUR APPOINTMENT

REVIEW OF SYSTEMS

Are you currently having or have you had problems with:

	YES	NO	Describe all yes responses:
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs/Breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Digestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel Movement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina/Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Burn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Balance problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blackout/fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
TB	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____

PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Approx Date	Surgeries/Hospitalizations	Approx Date

PREVIOUS INJURY

Injury	Approx Date	Injury	Approx Date