*Date:*__________

Cadillac Orthopaedics

REGISTRATION INFORMATION

PATIENT INFORMATION:

PATIENT NAME: ______________________ MIDDLE INITIAL ________ SEX:________

BIRTH DATE______________ AGE: _____ SOCIAL SECURITY#:______________________

PATIENT ADDRESS____

CITY: ______________________ STATE:__________ ZIP CODE:______________

HOME PHONE: ______________________ALTERNATE PHONE:______________________

PARENT OR GUARDIAN RESPONSIBLE: ______________________________________

BIRTH DATE:______________ SOCIAL SECURITY#: ______________________

EMERGENCY CONTACT OR SPOUSE: ______________________ PHONE: ______________

FAMILY PHYSICIAN: ______________________ REFERRING PHYSICIAN: ______________

EMPLOYMENT INFORMATION:

PATIENT'S OR PARENT'S EMPLOYER: ______________________________________

EMPLOYER'S ADDRESS: ____

EMPLOYER'S PHONE: ______________________

INSURANCE INFORMATION:

PRIMARY INSURANCE: ______________________ POLICY#:______________

SUBSCRIBER: ______________________________ GROUP#: ______________

SOCIAL SECURITY#: ______________________ BIRTH DATE:______________

EMPLOYER: ______________________________ PHONE: ______________________

SECONDARY INSURANCE: ______________________ POLICY:______________

SUBSCRIBER:______________________ GROUP#:__________ BIRTH DATE:__________

IS CONDITION RELATED TO: WORK_____ AUTO _____ SCHOOL / SPORTS _____ OTHER _____

DATE OF INJURY / ACCIDENT: __________

PERSON TO AUTHORIZE TREATMENT IF WORK RELATED:______________________

PATIENT SIGNATURE: ____

Cadillac Orthopaedics

8872 Professional Drive, Ste B
Cadillac, MI 49601
Telephone 231-779-0320
Fax 231-779-1367

Radiology Tests (X-Ray Films)
Important Information: Please Read

If you have had any of the following tests:

X-Rays, MRI, Bone Scan, CT Scan ("CAT" Scan), then

You will need to bring the ACTUAL FILMS to your office visit. You may sign out and borrow the films from the Radiology (X-Ray) Department where the films were taken.

The physicians at Cadillac Orthopaedics are bone and joint specialists who will need to actually see your films during your office visit.

The ONLY way to be sure these films will be available for your office visit is to HAND CARRY them with you. Please DO NOT rely on your regular medical doctor's office or the hospital to send them to us. They do not and will not send us the films.

Unfortunately, if you arrive without your films, your appointment at Cadillac Orthopaedics may have to be rescheduled.

Please call our office staff at 231-779-0320 for assistance if you have any questions.

Thank you!

Cadillac Orthopaedics Medical Questionnaire

Appointment Date: ____________ Chart# ____________ Doctor ☐ B ☐ K

Patient Name (Print): ______________________________________

Birth Date: ____________ Age: [ ] Sex: ☐ M ☐ F Dominant Hand: ☐ R ☐ L ☐ Either

Height: ____________ Weight: ____________ Did you bring X-rays? ☐ Y ☐ N

Who requested that you see us? ____________________ ☐ MD/DO ☐ PA/RN ☐ Attorney ☐ Employer ☐ Self

♦What is the main reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ ________ (CC)

♦ What body part is involved? Please mark in table below. **If you have <u>more than one</u>, see receptionist.** (Location)

Neck ☐	and **shoots** to	☐ R Arm ☐ L Arm ☐ Neither	Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Wrist ☐ R ☐ L	Thumb ☐ R ☐ L	Pelvis ☐ R ☐ L	Thigh ☐ R ☐ L	Calf/Shin ☐ R ☐ L	Foot ☐ R ☐ L
Back ☐	and **shoots** to	☐ R Arm ☐ L Arm ☐ Neither	Arm ☐ R ☐ L	Forearm ☐ R ☐ L	Hand ☐ R ☐ L	Finger 2345 ☐ R ☐ L	Hip ☐ R ☐ L	Knee ☐ R ☐ L	Ankle ☐ R ☐ L	Toe B2345 ☐ R ☐ L

♦ How long ago did it start? ___Days ___Weeks ___Months ___Years Have you had a problem like this before? ☐ Y ☐ N (Duration)

In this section, check the <u>ONE</u> Box which best describes how your problem started. Then answer the questions below the box you checked. *USE THE SPACES ON THE RIGHT* as needed.

☐ NO INJURY: Onset was ☐ Gradual ☐ Sudden ____ ______________ (Context)
Why do you think it started? ____________ ______________

☐ INJURY AT WORK Date ____________ From a: ______________
☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐ reach ☐ other ______________

☐ INJURY ☐ Accident ☐ Sport <u>NOT</u> Auto/Work ___ ______________
Date ____________ Where and How did it happen? ______________
What sport? ____________ School ____________ ______________

☐ WORK RELATED, BUT NO INJURY ____________ ______________
Date ____________ How did you job cause this problem? ______________

☐ AUTO ACCIDENT Date ________ How was your car hit? ______________

♦**On a scale of 0-10 (10 is the worst), how severe** is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10 **(Severity)**

♦What is the **<u>quality</u>** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning **(Quality)**

The pain is: ☐ Constant ☐ Comes and goes (intermittent) ☐ Worse in AM ☐ Worse in PM **(Timing)**

Does your pain wake you from sleep? ☐ Y ☐ N **(Timing)**

Do you have? ☐ Swelling ☐ Catching/Locking ☐ <u>Numbness</u> ☐ Weakness **(Assoc Symp or <u>Neuro ROS)</u>**
☐ Bruising ☐ Instability ☐ <u>Tingling</u> ☐ Loss of bowel or bladder control

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

What makes your symptoms **<u>worse</u>**? ☐ Standing ☐ Exercise ☐ Bending ☐ Stairs ☐ Sneezing **(Mod)**
☐ Walking ☐ Twisting ☐ Squatting ☐ Sitting ☐ ________
☐ Lifting ☐ Lying in bed ☐ Kneeling ☐ Coughing

What makes your symptoms **<u>better</u>**? ☐ Rest ☐ Ice ☐ Medication ☐ Other ____________ **(Mod)**
☐ Elevation ☐ Heat ☐ Exercise

What medications are you taking now (or previously) for this problem? ______________ **(Mod)**

Which of these treatments have you had? ☐ Injection ☐ Brace ☐ Physical Therapy ☐ Cane/Crutch ☐ Walker **(Mod)**

Were you seen in the Emergency Room (ER) for this problem? ☐ Y ☐ N Which ER? ____________

Are you here today as a result of the ER visit? ☐ Y ☐ N

Who saw you in the ER? (name) ____________ ☐ MD/DO ☐ PA ☐ Don't Know

What tests/scans have you had for this problem? ☐ X-Rays ☐ CAT scan ☐ Nerve Test (EMG/NCV)
☐ MRI ☐ Bone scan ☐ Other ____________

Have you already had surgery for a problem in this same area either recently or in the past ☐ Y ☐ N Please list below.

Surgery #1 ____________ Surgeon ____________ City ____________ Date ________
Surgery #2 ____________ Surgeon ____________ City ____________ Date ________

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Cadillac Orthopaedics Medical Questionnaire

Appointment Date: ____________ Chart # ____________ Doctor ☐ B ☐ K

Patient Name (Print): ______________________________

Current Work Status? ☐ Regular ☐ Light duty (How long?________) ☐ Student
☐ Disabled ☐ Not working due to this problem (How long?________) ☐ Laid Off
☐ Retired ☐ Not working

When is the last date you worked your regular job?______________

Are you currently receiving or plan to apply for (check all that apply): ☐ Disability
☐ Workers Compensation
☐ Unemployment

REVIEW OF SYSTEMS: Please check all that apply

1) M/S Have you had a **prior** problem with this **same** orthopaedic condition in the past? ☐ Y ☐ N

If yes, please explain:______________________________

☐ My other joints have morning stiffness lasting over 30 min ☐ Rheumatoid arthritis
☐ Joint pain or swelling ☐ Osteoporosis
☐ Prior fracture (which bone)______________ ☐ Back pain
☐ Gout ☐ None of the above

N2E3 (MS)

Have You Had Any Of These Symptoms? If Not, Mark NO		Year	Explain Details/Comments
2)GI	☐ Heartburn ☐ Diarrhea/loose stools ☐ Ulcers ☐ Blood in stool ☐ Nausea ☐ Hepatitis/yellow jaundice ☐ Vomiting ☐ Liver Disease	☐ NO	
3)End	☐ Thyroid disease ☐ Excessive urination ☐ Heat/Cold intolerance ☐ Excessive thirst	☐ NO	
4)Con	☐ Fever ☐ Weight loss ☐ Chills ☐ Weight gain ☐ Loss of appetite ☐ Weakness	☐ NO	
5)Eye	☐ Blurred vision ☐ Glasses ☐ Double vision ☐ Contacts ☐ Vision loss	☐ NO	
6)ENT	☐ Hearing loss ☐ Sore throat ☐ Hoarseness ☐ Trouble swallowing ☐ Earache	☐ NO	
7)CV	☐ Chest pain ☐ Blood Clots ☐ Murmur ☐ Palpitations ☐ Poor circulation	☐ NO	
8)Res	☐ Chronic cough ☐ Coughing blood or phlegm ☐ Wheezing ☐ Shortness of breath	☐ NO	
9)GU	☐ Painful urination ☐ Blood in urine ☐ Frequent urination ☐ Kidney problems	☐ NO	
10)Skin	☐ Rashes ☐ Lumps ☐ Skin ulcers ☐ Psoriasis	☐ NO	
11)Neu	☐ Headaches ☐ Seizures ☐ Dizziness ☐ Fainting	☐ NO	
12)Psy	☐ Depression ☐ Psychiatric history ☐ Anxiety ☐ Sleep disorder ☐ Drug/Alcohol addiction	☐ NO	
13)Hem	☐ Easy bleeding ☐ Anemia (low blood count) ☐ Easy bruising	☐ NO	
14)Imm	☐ Hives ☐ Hayfever ☐ Chronic steroids ☐ AIDS ☐ Allergies (NOT to medication)	☐ NO	

N3E4 (2+)

N4,5 E5 (10)

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Cadillac Orthopaedics Medical Questionnaire

Appointment Date: ____________ Chart# ____________ Doctor ☐ B ☐ K

Patient Name (Print): ________________________________

N3E4 (1)

♦PAST MEDICAL HISTORY

Are You A Diabetic? ☐ **Y** ☐ **N** **Treatment:** ☐ **Insulin** ☐ **Oral Meds** ☐ **Diet** ☐ **None**

N4,5 E5 (1)

Are You Taking, Or Have You Ever Taken, Blood Thinners? ☐ **Y** ☐ **N**

If yes, choose: ☐ Coumadin ☐ Ticlid ☐ Aspirin ☐ Plavix ☐ Persantine ☐ Anti-inflammatory ☐ Other____________

Past Hospitalizations (NOT for surgery), please list: ☐ **None**

Year	Reason for Hospitalization

Have you ever had:

- ☐ Heart attack (year) ______
- ☐ Heart failure
- ☐ Blood clots (year) ______
- ☐ Stroke
- ☐ Ankle swelling
- ☐ High blood pressure
- ☐ Kidney failure
- ☐ Asthma
- ☐ Sulfa allergy
- ☐ Aspirin sensitivity
- ☐ Stomach ulcers
- ☐ Bleeding ulcers
- ☐ Stomach ache taking anti-inflammatories (includes Advil/Aleve)
- ☐ Cancer (location)__________

☐ **I have never had any of the above conditions**

N4,5 E5 (1)

♦FAMILY HISTORY: Have any direct relatives had any of the following problems? If so, which relative?

- ☐ Diabetes________
- ☐ High Blood Pressure________
- ☐ Heart Disease________
- ☐ Rheumatoid Arthritis________
- ☐ Other______________
- ☐ NONE of my relatives have problems

Do any direct relatives have the SAME CONDITION that you are being seen for today? ☐ Y ☐ N

If yes, relation to you________________

N4,5 E5 (1)

♦SOCIAL HISTORY:

Marital Status ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced

How many other people live with you?_____

Occupation:________________________

Employer:________________________

Do you like your job? ☐ Y ☐ N

Do you plan to be working 6 months from now? ☐ Y ☐ N

Using tobacco NOW? ☐ Y ☐ N

If yes: ☐ Cigarettes____Packs per day for____yrs ☐ Chew ☐ Cigar/Pipe

Quit Smoking? ☐ This year ☐ _____yrs ago

Used to smoke____packs per day for____yrs

Use alcohol? ☐ Y ☐ N

If yes, how often? ☐ Daily ☐ _____drinks per week ☐ Rarely ☐ Recovering alcoholic ☐ None

History of substance abuse? ☐ Y ☐ N

PLEASE SIGN: The information on these forms is acurate to the best of my knowledge.__________________

Thank you for your help!!

For Office Use Only

Complete____**Date**__/__/__ **Review #1 by**________________ **Date**__/__/__

Review #2 by________________ **Date**__/__/__

BP____/____Pulse____

Temp____Ht____/____ ____Wt____

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Cadillac Orthopaedics Medical Questionnaire

Appointment Date: ____________ Chart# ____________ Doctor ☐ B ☐ K

Patient Name (Print): ______________________________

N3E4 (1)

PAST MEDICAL HISTORY

ALLERGIES ☐ **I have no known allergies to medications**

N4,5 E5 (1)

Are you allergic to anything: such as *drugs, IVP dye, iodine on skin, latex rubber, eggs, tape, etc?*
If yes, what reaction do you get: such as *rash, nausea, stomach upset, hives, throat swelling, etc?*

Name of Drug or Allergic Substance	Reaction That Happens
	☐ Hives ☐ Rash ☐ Itching ☐ Throat swelling ☐ Nausea ☐ Other
	☐ Hives ☐ Rash ☐ Itching ☐ Throat swelling ☐ Nausea ☐ Other
	☐ Hives ☐ Rash ☐ Itching ☐ Throat swelling ☐ Nausea ☐ Other
	☐ Hives ☐ Rash ☐ Itching ☐ Throat swelling ☐ Nausea ☐ Other
	☐ Hives ☐ Rash ☐ Itching ☐ Throat swelling ☐ Nausea ☐ Other
	☐ Hives ☐ Rash ☐ Itching ☐ Throat swelling ☐ Nausea ☐ Other

What MEDICATIONS Do You Take? ☐ **I take no medications**
(Please include prescription and non-prescription medication.

Date	Name of Medication	Dose	Times Per Day	Reason You Take It

PAST SURGICAL HISTORY: What operations have you had?

☐ **I have never had any surgery**

Year	Operation	Year	Operation
☐ ________	Adenoidectomy	☐ ________	Mastectomy (Breast removal)
☐ ________	Appendectomy (Appendix removal)	☐ ________	Orthopaedic Surgery (Describe)____________
☐ ________	Arthroscopy (Scope) (Describe)____________	☐ ________	Prostate (Describe)____________
☐ ________	Breast Biopsy	☐ ________	Tonsillectomy
☐ ________	Carotid artery	☐ ________	Total Joint Replaced (Describe)____________
☐ ________	Cataract	☐ ________	Tubal Ligation (Tubes tied)
☐ ________	Carpal Tunnel	☐ ________	Vascular(describe)____________
☐ ________	C-section (Caesarian for childbirth)		
☐ ________	Cholecystectomy (Gallbladder)	☐ ________	Other____________
☐ ________	Coronary Artery Bypass (Open heart)		
☐ ________	D&C (Dilation/curettage)	☐ ________	Other____________
☐ ________	Hemorrhoidectomy (Hemorrhoids, piles)		
☐ ________	Herniorrhaphy (Hernia, rupture)	☐ ________	Other____________
☐ ________	Hysterectomy (Uterus)		

Have you ever had a reaction to or problem with anesthesia? ☐ Y ☐ N

If yes, choose: ☐ Nausea ☐ Slow awakening ☐ Pseudocholinesterase deficiency
☐ Vomiting ☐ Malignant hyperthermia ☐ Other____________

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