MSOC
Michigan SportsMedicine
and Orthopedic Center
www.michigansportsmedicine.com

- John K. Anderson, MD
- John K. Morris, MD

- Orthopedic Surgery
- Physical Therapy
- Sports Fitness

4972B Clark Rd.
Suite 200
Ypsilanti, MI 48197
734.434.3020
734.434.3025 Fax

If this visit is related to Worker's Comp, an Auto Injury, or a Public Liability claim, please alert the front desk staff immediately!

PATIENT DEMOGRAPHIC INFORMATION (Please print)

Today's Date: _____

Name: _____ DOB: ___/___/___ SS#: _____
LAST FIRST M.I.

Address: _____
STREET CITY STATE ZIP

Primary Phone: _____ Secondary Phone: _____

Work Phone: _____ Email: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ White ☐ Type-Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Type-Unknown

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Creole ☐ Other: _____

May we leave routine messages on your personal answering machine/voice mail? ☐ Yes ☐ No Which phone number? _____

May we share your protected health information with a family member? ☐ Yes ☐ No

Please list names: _____

Name of emergency contact: _____ Relationship: _____

Phone: _____ Alternative phone: _____

Are you coming from a skilled nursing facility? ☐ Yes ☐ No

Name of facility: _____ Address: _____

Please give your insurance card and ID to front desk.

DATE OF INJURY:

FOR OFFICE USE ONLY

INITIALS:

Primary Insurance: _____

Policy Holders Name: _____ DOB: _____

Second Insurance: _____

Policy Holders Name: _____ DOB: _____

Third Insurance: _____

Policy Holders Name: _____ DOB: _____

Patients under 18 must be accompanied by a parent or guardian

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HEALTH HISTORY (CONFIDENTIAL)

Patient Name: _____ Today's Date: _____

Symptom or problem for which you are seeing the doctor today _____

Birth Date: _____ Pharmacy name and phone number: _____

Referring Doctor: _____ Cardiologist: _____

SYMPTOMS: CHECK (✔) SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

GENERAL
- ☐ Anxiety
- ☐ Balance problems
- ☐ Chills
- ☐ Depression
- ☐ Difficulty Walking
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headache
- ☐ Hot Flashes
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Numbness

WOMEN ONLY
Menopause: ☐ Yes ☐ No

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders
- ☐ Groin

GENITO-URINARY
- ☐ Lack of bladder control
- ☐ Difficulty/Pain urinating

GASTROINTESTINAL
- ☐ Bowel Changes
- ☐ Lack of Bowel Control
- ☐ Heartburn/Indigestion
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Stomach Pain

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Rapid Heart Beat
- ☐ Sleep Apnea
- ☐ Swelling of ankles

EYE, EAR, NOSE, THROAT
- ☐ Difficulty Swallowing
- ☐ Loss of Hearing
- ☐ Sinus Problems

SKIN
- ☐ Bruise Easily
- ☐ Itching
- ☐ Rash

Current Height: _____
Current Weight: _____
Physician Notes:
_____
_____
_____
_____
_____
_____
_____
_____

SYMPTOMS: CHECK (✔) CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bi-Polar Disorder
- ☐ Bleeding Disorders
- ☐ Blood Pressure, High
- ☐ Bronchitis
- ☐ Cancer _____
- ☐ Cerebral Palsy
- ☐ Chemical Dependency
- ☐ Cirrhosis of Liver
- ☐ COPD
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fractures _____
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis Type A, B, C
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Legally Blind
- ☐ Liver Disease
- ☐ Lupus
- ☐ Meningitis
- ☐ Migrane Headaches
- ☐ Multiple Scierosis
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostrate Problem
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer in Stomach
- ☐ Ulcers of Skin
- ☐ Other _____

FAMILY HISTORY: CHECK (✔) ALL THAT APPLIES AND INDICATE THEIR RELATIONSHIP TO YOU

- ☐ Heart Disease _____
- ☐ Arthritis _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Osteoporosis _____
- ☐ Scoliosis _____

SOCIAL HISTORY:

Do you exercise? ☐ Yes ☐ No Type of exercise: _____ Times per week: _____

Tobacco Use: ☐ Current every day smoker ☐ Current some day smoker ☐ Never smoker ☐ Former smoker

Alcohol Use: ☐ None ☐ Social ☐ Moderate ☐ Heavy

Employer/Occupation: _____ Are you able to work now? ☐ Yes ☐ No

Is your current problem related to work or an accident? ☐ Yes ☐ No Is there an attorney working with you? ☐ Yes ☐ No

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HEALTH HISTORY (CONFIDENTIAL) – continued

LIST ALL MEDICATIONS (PRESCRIPTIONS AND NON-PRESCRIPTIONS) YOU ARE PRESENTLY TAKING, INCLUDE FREQUENCY AND DOSE

MEDICATION NAME	DOSE	HOW OFTEN PER DAY
■		
■		
■		
■		
■		
■		
■		
■		
■		
■		
■		
■		
■ Are you taking any blood thinners (Coumadin, Heparin, Plavix, Aspirin)		
■		
■		
■		

Do you have any allergies to medications and foods? ☐ Yes ☐ No
If yes, please list: _____

Do you have skin sensitivity or allergy to metals? ☐ Yes ☐ No
If yes, please list: _____

LIST ALL SURGICAL PROCEDURES YOU HAVE HAD AND THE APPROXIMATE DATE:

SURGICAL PROCEDURE	DATE
■	
■	
■	
■	
■	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Legal Guardian Signature: _____

Review by: _____ Date: _____

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