Michigan Orthopedic Center

**J. Wesley Mesko, MD**

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**Name:_____Today's Date:_____Date of Birth:_____**

**Why are you seeing the doctor today?_____**

**Current problem is the result of: (Check all that apply)**

☐ **Car Accident** ☐ **Work Accident** ☐ **Accident** ☐ **I do not know what brought it on**

**Other_____**

*****If you have too many medical problems, surgeries, medications, or allergies to fit on this form, we kindly ask you to list them on a separate sheet of paper. Thank you!***

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**Are you currently or have you had problems with:**

***Circle one:***

| | | | | | |
|---|---|---|---|---|---|
| **NO** | **YES** | **Fibromyalgia** | **NO** | **YES** | **Congestive Heart Failure** |
| **NO** | **YES** | **Lupus** | **NO** | **YES** | **Irregular Heart Beat** |
| **NO** | **YES** | **Osteoarthritis** | **NO** | **YES** | **Heart Valve Problems** |
| **NO** | **YES** | **Rheumatoid Arthritis** | **NO** | **YES** | **Cardiac Catheterization** |
| **NO** | **YES** | **Asthma/Chronic Lung Disease** | **NO** | **YES** | **Stent Placement** |
| **NO** | **YES** | **Bladder/Kidney Problems** | **NO** | **YES** | **Hepatitis** |
| **NO** | **YES** | **Prostate Disease** | **NO** | **YES** | **Hiatal Hernia/Reflux/GERD** |
| **NO** | **YES** | **Urinary Incontinence** | **NO** | **YES** | **HIV/TB/Polio *(if yes circle one)*** |
| **NO** | **YES** | **Frequent Urinary Tract Infections** | **NO** | **YES** | **Hypertension** |
| **NO** | **YES** | **Kidney Failure** | **NO** | **YES** | **Poliomyelitis** |
| **NO** | **YES** | **Bleeding Problems/Easy Bruising** | **NO** | **YES** | **Seizure Disorder** |
| **NO** | **YES** | **Anemia** | **NO** | **YES** | **Stomach Ulcers** |
| **NO** | **YES** | **Blood Clot or Pulmonary Emboli** | **NO** | **YES** | **Stroke or TIA** |
| **NO** | **YES** | **Diabetes mellitus** | **NO** | **YES** | **Thyroid Disease** |
| **NO** | **YES** | **Chest Pain** | | | |

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**Are you currently or have you had problems with:**

***Circle one:***

| | | | | | |
|---|---|---|---|---|---|
| **NO** | **YES** | **Fatigue** | **NO** | **YES** | **Seen by a doctor who has manipulated my back** |
| **NO** | **YES** | **Weight Gain >10lbs** | | | |
| **NO** | **YES** | **Weight Loss >10lbs** | **NO** | **YES** | **Multiple Joints Hurt** |
| **NO** | **YES** | **Psoriasis** | **NO** | **YES** | **Decreased Memory** |
| **NO** | **YES** | **Sleep Apnea** | **NO** | **YES** | **Dizziness** |
| **NO** | **YES** | **Use CPAP at nighttime** | **NO** | **YES** | **Seizures** |
| **NO** | **YES** | **Difficulty Breathing** | **NO** | **YES** | **Stroke** |
| **NO** | **YES** | **Constipation** | **NO** | **YES** | **Unsteadiness** |
| **NO** | **YES** | **Heart Burn** | **NO** | **YES** | **Anxiety** |
| **NO** | **YES** | **Back Pain** | **NO** | **YES** | **Depression** |
| **NO** | **YES** | **Seen by Chiropractor for Back Pain** | **NO** | **YES** | **Panic Attacks** |
| **NO** | **YES** | **Seen by Pain Clinic for Back Pain** | **NO** | **YES** | **Thyroid Problems** |

**Describe any medical issues not listed above:_____**

_____

_____

| Allergies: | Reaction? |
|---|---|
| | |
| | |

| Current Medications: | Dose | How Long? |
|---|---|---|
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| Surgeries/Hospitalizations | Year | Complications |
|---|---|---|
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**FAMILY HISTORY**

| Member | Status Please Circle | Age Now or at Death | Health Condition or Cause of Death |
|---|---|---|---|
| Father | Alive Dead | | |
| Mother | Alive Dead | | |
| Sister/Brother | Alive Dead | | |
| Sister/Brother | Alive Dead | | |
| Sister/Brother | Alive Dead | | |
| Sister/Brother | Alive Dead | | |

**SOCIAL HISTORY**

Current Occupation_____ ☐ Retired ☐ Don't work outside home ☐ Student
☐ Disabled since when_____ ☐ Last date worked_____
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐ Roommate(s) ☐ Significant Other
Do you live alone? No Yes
If yes, do you have any family/friends who can assist you?_____
Children No Yes #_____
Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
What type of exercise?_____
History of substance abuse? No Yes What?_____
Smoke Currently? No Yes _____packs per day for _____years.
Quit Smoking? ☐ This year ☐ >1 year ☐ >5 years ☐ >10 years
Previously smoked…. _____packs per day for _____years.
Drink alcohol? ☐ Daily ☐ 1-2x per week ☐ 1-2x per month ☐ 1-2x per year ☐ Neve
Current Height_____ Current Weight_____