NEW ENGLAND ORTHOPEDIC SURGEONS

HISTORY AND PHYSICAL EXAMINATION

300 Birnie Avenue, Suite 201 • Springfield, MA 01107-1107
(413) 785-4666 • www.neortho.com

Date ______________________ Acct # ______________________

Patient's Name ______________________ Date of Birth ____/____/____

Primary Care Doctor ______________________ Referral Doctor (if different) ______________________

Reason for Visit *(Chief Complaint)* ______________________

Date of first symptoms ____/____/____ ☐ MVA ☐ Work related ______________________ *Date of Injury*

PAST MEDICAL HISTORY:

SURGICAL PROCEDURES: *(Include dates)*

REVIEW OF SYSTEMS: *(Check all that apply)*

Yes	No		Yes	No		Yes	No	
☐	☐	Headaches	☐	☐	Stomach, ulcer, intestinal problems	☐	☐	Anemia
☐	☐	Seizures				☐	☐	Cancer
☐	☐	Strokes	☐	☐	Cholesterol	☐	☐	Hepatitis
☐	☐	Arthritis	☐	☐	Breathing or lung disorders	☐	☐	Phlebitis or blood clots
☐	☐	Nerve disorders	☐	☐	Kidney/Bladder problems	☐	☐	Ease of bruising
☐	☐	Circulation problems	☐	☐	Thyroid problems	☐	☐	Prolonged bleeding
☐	☐	Heart trouble	☐	☐	Diabetes	☐	☐	Emotional or psychiatric difficulties
☐	☐	High blood pressure	☐	☐	Lyme Disease			
☐	☐	Inflammatory joint disease	☐	☐	HIV/Aids	☐	☐	Other medical problems

MEDICATION USAGE:

Med	Dose	Times/day	Med	Dose	Times/day	Med	Dose	Times/day

ALLERGIES: ☐ Latex ☐ Food *(Specify)* ______________________
☐ Iodine ☐ Drugs *(Specify)* ______________ Reaction: ______________

VITAL SIGNS: 1. Height ________ ft. ________ in. 2. Weight: ________ lbs.

SOCIAL HISTORY: *(Please Circle)* Single / Married Children Yes / No

Habits: Alcohol consumption: ________ Tobacco: ________ Street drugs: ________

PERTINENT FAMILY HISTORY:

Parents/siblings/children ages and medical conditions. *(If deceased, age and cause of death)*

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Init./date:	Init./date:	Init./date:	Init./date:	Init./date:	Init./date: