NEOS
NEW ENGLAND ORTHOPEDIC SURGEONS

HISTORY AND PHYSICAL EXAMINATION

300 Birnie Avenue, Suite 201 • Springfield, MA 01107-1107
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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	☐	☐	Cholesterol	☐	☐	Cancer
☐	☐	Strokes	☐	☐	Breathing or lung disorders	☐	☐	Hepatitis
☐	☐	Arthritis	☐	☐	Sleep Apnea	☐	☐	Phlebitis or blood clots
☐	☐	Nerve disorders	☐	☐	Use a CPAP machine	☐	☐	Ease of bruising
☐	☐	Circulation problems	☐	☐	Kidney / Bladder problems	☐	☐	Bleeding disorder
☐	☐	Heart trouble	☐	☐	Thyroid problems	☐	☐	Factor V Leiden
☐	☐	High blood pressure	☐	☐	Diabetes	☐	☐	Emotional or psychiatric difficulties
☐	☐	Inflammatory joint disease	☐	☐	Lyme Disease	☐	☐	Other medical problems
			☐	☐	HIV/Aids			

MEDICATION USAGE:

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

PHARMACY: _____

ADDRESS: _____

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)*