Northeast Orthopaedic & Hand Surgery PC

NORTHEAST ORTHOPAEDIC
& HAND SURGERY, P.C.
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ORTHOPAEDIC SURGERY
UPPER EXTREMITY AND HAND SURGERY
ARTHROSCOPIC SURGERY
SPORTS MEDICINE
HIP AND KNEE REPLACEMENTS
TRAUMA SURGERY
SPINE CARE AND SURGERY
ARTHRITIS SURGERY
FOOT AND ANKLE SURGERY

MEDICAL HISTORY

Today's Date:_____

Name:_____Date of Birth:_____
First M.I. Last

Reason for visit (state specific body part and injury):_____

When did this occur?_____ Where did this occur?_____

Who referred you to our office?_____

Height:_____ Weight:_____

Have you had X-rays relating to this? Yes___ No___ If so, where were they taken?_____

List all medications you are currently taking:_____

List all allergies to medications:_____

Are you allergic to Seafood (Iodine?)_____ Cortisone_____ Latex_____ Other_____

Please check the boxes below if you currently have any of the listed medical conditions:

- ☐ Acid Reflux
- ☐ Alzheimer's Disease
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ MRSA
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Traumatic Brain Injury
- ☐ Acute M.I.
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Gout
- ☐ Hypercholesterolemia
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Pre-Hypertension
- ☐ Stroke
- ☐ Other:_____
- ☐ ADHD
- ☐ Rheumatoid Arthritis
- ☐ BPH
- ☐ CNS Vascular Disorders
- ☐ Chrohn's Disease
- ☐ Diabetes
- ☐ Headache
- ☐ Hypertension
- ☐ Lyme Disease
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Thyroid Disorders

List all surgeries and dates:_____

Are you left-handed, right-handed, or ambidextrous?_____ Are you pregnant?_____

Family History: Please indicate if any immediate family members currently have/had any of the following:

- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Kidney Disease
- ☐ Uterine Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Thyroid Disease
- ☐ Osteoarthritis
- ☐ Ovarian Cancer
- ☐ Colon Cancer
- ☐ Arthritis
- ☐ Stroke
- ☐ Blood Clots
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Other Cancer
- ☐ Other: _____

Social History:
Occupation:_____

Employer Name:_____ Employer Phone: _____

Do you work: Part Time_____ Full Time_____ Unemployed_____ Retired_____ Student_____

Are you currently on disability? Yes_____ No_____ Are you currently in school? Yes_____ No____

List any sport, recreational or leisure activity in which you participate:_____

Do you smoke? Yes____ No____ Never____ If yes, how often? _____

Do you drink alcohol? Yes____ No____ If yes, how many drinks? ____ How often?_____

Do you use recreational drugs? ? Yes_____ No_____

What is your marital status? Single_____ Married_____ Divorced_____ Widowed_____

Please check if you are experiencing any of the following symptoms:

Constitutional
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Generalized Pain

Respiratory
- ☐ Shortness of Breath
- ☐ Cough

Urinary
- ☐ Burning during urination
- ☐ Increased frequency

Hematologic
- ☐ Bruising
- ☐ Bleed easily

Ear, Nose, Throat
- ☐ Earache
- ☐ Nosebleeds
- ☐ Sore Throat

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain, general
- ☐ Joint Pain, localized

Psychological
- ☐ Depression
- ☐ Anxiety

Cardiovascular Symptoms
- ☐ Chest Pain
- ☐ Palpitations

Endocrine
- ☐ Excessive Thirst
- ☐ Muscle Weakness

Skin
- ☐ Rash
- ☐ Itching
- ☐ Wound

Neurological
- ☐ Headache
- ☐ Dizziness
- ☐ Poor Coordination

Attorney Name and Phone:_____

Is there a third party Liability for this injury? _____

Thank you for completing this form.
We appreciate your patience as we transition to Electronic Medical Records.