New England Orthopedic Specialists
your health, our expertise

HEALTH HISTORY FORM

Your Health History Form needs to be updated yearly, and every time you have a new problem.

Today's date: ____________________ Which physician are you seeing today? ______________________________

Patient name: ______________________________ DOB: ______________ Age: __________
Primary care doctor: ______________________ Who referred you? ______________________
Reason for this appointment: ____
____
Have you had x-rays taken? Yes No If yes, where \ when? ______________________
Did you bring x-rays with you? Yes No Are you right\left handed? Right Left
When did your orthopedic problem start? ______________________________________
Brief history of your orthopedic problem: ______________________________________
____

Pain Scale: circle the appropriate number	0	1 2 3 4	5 6	7 8 9	10
	None	Mild	Moderate	Severe	Worst

Occupation: ______________________ Is this a worker's compensation injury? Yes No
Were you at work when this injury occurred? Yes No Have you reported this injury to your employer? Yes No
Is there a lawsuit pending with this problem? Yes No Was this due to a motor vehicle accident? Yes No
Sports \ leisure activities: ____

Previous surgeries:
____
____
____

List all medications and dose:
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Allergies to medications:
____

Are you: Single Married Separated Divorced Widow Widower Who do you live with? ______________
Do you have children? Yes No If so, How many? ______________ Ages? ______________
Do you smoke? Yes No If so, How many packs per day? ________ For how many years? ______________
Do you drink alcohol? Yes No If so, How many drinks per day? ________
Height: ______________ Weight: ______________

Medical Problems: (please circle all that apply)

Heart attack	Heart disease	Atrial fibrillation	Cancer --Type: ___________	Stroke
Thyroid condition	Diabetes	Stomach ulcers	Kidney problems	Liver problems
Emphysema\COPD	Aneurysm	Anemia	High blood pressure	Blood clots

Medical history of your parents and/or siblings: please circle all that apply

Adopted	Heart disease	High blood pressure	Blood Clots
Stroke	Arthritis	Cancer--Type: ___________	

System Review: (please circle all that apply**)**

General:	Fever Chills Runny nose Weight loss Weight gain
Nervous System:	Headache Stroke Memory loss Seizure Fainting Dizziness Numbness
Hearing:	Hearing loss Ringing in the ears Hearing aid
Vision:	Glasses Contact lenses Cataracts Glaucoma Double vision Retina problems
Heart:	Chest pain Palpitations
Lungs:	Shortness of breath Cough Asthma Pneumonia
Digestive:	Heartburn Reflux Nausea Vomiting Gastritis Diarrhea Constipation Colitis
Liver:	Hepatitis Cirrhosis Gallstones
Urinary System:	Trouble urinating Burning Frequency Infections Incontinence Kidney stones
Circulation:	Bleeding problems Leg ulcers Peripheral vascular disease Phlebitis
Musculoskeletal:	Gout Fibromyalgia Osteoporosis Rheumatoid arthritis
Skin:	Rashes Skin cancer Psoriasis Infections
Allergies:	Iodine Latex Shellfish Metal intolerance
Mental Health:	Depression Anxiety Mood swings Panic attacks