



NEW ENGLAND
ORTHOPEDIC SURGEONS

HISTORY AND PHYSICAL EXAMINATION

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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
<input type="checkbox"/> <input type="checkbox"/> Headaches _____	<input type="checkbox"/> <input type="checkbox"/> Stomach, ulcer, intestinal problems _____	<input type="checkbox"/> <input type="checkbox"/> Anemia _____
<input type="checkbox"/> <input type="checkbox"/> Seizures _____	<input type="checkbox"/> <input type="checkbox"/> Cholesterol _____	<input type="checkbox"/> <input type="checkbox"/> Cancer _____
<input type="checkbox"/> <input type="checkbox"/> Strokes _____	<input type="checkbox"/> <input type="checkbox"/> Breathing or lung disorders _____	<input type="checkbox"/> <input type="checkbox"/> Hepatitis _____
<input type="checkbox"/> <input type="checkbox"/> Arthritis _____	<input type="checkbox"/> <input type="checkbox"/> Sleep Apnea _____	<input type="checkbox"/> <input type="checkbox"/> Phlebitis or blood clots _____
<input type="checkbox"/> <input type="checkbox"/> Nerve disorders _____	<input type="checkbox"/> <input type="checkbox"/> Use a CPAP machine _____	<input type="checkbox"/> <input type="checkbox"/> Ease of bruising _____
<input type="checkbox"/> <input type="checkbox"/> Circulation problems _____	<input type="checkbox"/> <input type="checkbox"/> Kidney/Bladder problems _____	<input type="checkbox"/> <input type="checkbox"/> Bleeding disorder _____
<input type="checkbox"/> <input type="checkbox"/> Heart trouble _____	<input type="checkbox"/> <input type="checkbox"/> Thyroid problems _____	<input type="checkbox"/> <input type="checkbox"/> Factor V Leiden _____
<input type="checkbox"/> <input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> <input type="checkbox"/> Diabetes _____	<input type="checkbox"/> <input type="checkbox"/> Emotional or psychiatric difficulties _____
<input type="checkbox"/> <input type="checkbox"/> Inflammatory joint disease _____	<input type="checkbox"/> <input type="checkbox"/> Lyme Disease _____	<input type="checkbox"/> <input type="checkbox"/> Other medical problems _____
	<input type="checkbox"/> <input type="checkbox"/> HIV/Aids _____	

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*)

❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ THANK YOU FOR COMPLETING – PLEASE STOP HERE ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖

Temp: _____	Temp: _____	Temp: _____	Temp: _____	Temp: _____	Temp: _____
Pulse: _____	Pulse: _____	Pulse: _____	Pulse: _____	Pulse: _____	Pulse: _____
Pain Score: _____	Pain Score: _____	Pain Score: _____	Pain Score: _____	Pain Score: _____	Pain Score: _____
Resp: _____	Resp: _____	Resp: _____	Resp: _____	Resp: _____	Resp: _____
Init./date: _____	Init./date: _____	Init./date: _____	Init./date: _____	Init./date: _____	Init./date: _____
Init./date: _____	Init./date: _____	Init./date: _____	Init./date: _____	Init./date: _____	Init./date: _____