INITIAL HEALTH HISTROY & EVALUATION FORM

NEOS® NEW ENGLAND ORTHOPEDIC SURGEONS

NAME: _____

Age: _____ **Today's Date:**_____

Date of Birth: _____

Height: _____ **Weight:** _____

Who referred you to us? Who is your primary doctor?
If referred, please give name / address of the person/physician:

_____

Occupation? _____

Where is your problem? (please circle)

Shoulder Elbow Knee

Hip Other

Which side(s)? Right / Left / Both

Dominant Arm? Right / Left

Problem(s) (please check all that apply):

Pain
Weakness
Instability / giving way / dislocation?
Stiffness?
Swelling?
Other _____

How did you injure yourself?

No injury
Sports (which sport?)_____
Motor vehicle accident
Work / job –
Is there a workers comp claim? Yes / No

Sports level: none / recreational / college / professional

Date of injury?_____

How long have you had symptoms?
_____ Days _____ Mos. _____ Yrs.

Briefly describe your injury. Trauma or gradual onset?

_____

_____

Describe your pain (aching, sharp, stabbing, shooting etc).

_____

Previous treatments (other than surgery)?
(medications, physical therapy, injections, bracing)

_____

_____

Previous surgery for this problem (include dates)

_____

_____

How severe is the pain? ***(0 = none, 10 = worst pain of your life)***

At rest? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Do you have pain at night? Yes / No

Does it waken you from sleep? Yes / No

Are you currently working? Yes / No / Retired

☐ Normal job? ☐ Limited duty?

What makes your problem better?

_____

What makes your problem worse?

_____

Please describe your current limitations?

_____

Have you had any previous imaging studies?

X-rays	No / Yes	date:_____
MRI	No / Yes	date:_____
CAT scan	No / Yes	date:_____

PAST MEDICAL HISTORY:

- ❑ High blood pressure _____
- ❑ Heart problems _____
- ❑ History of Heart attack_____
- ❑ Stroke _____
- ❑ Seizures _____
- ❑ Asthma _____
- ❑ Gastritis _____
- ❑ Kidney disease _____
- ❑ History of Cancer _____
- ❑ Osteoporosis _____
- ❑ History of blood clot/embolus_____
- ❑ Blood clotting disorder_____
- ❑ Diabetes _____
- ❑ History of skin infections_____MRSA_____
- ❑ Other _____
  _____

MEDICATIONS: (please list all medications/doses you currently take or attach a separate list)

_____

_____

_____

ALLERGIES: (please also list your allergic reaction if any such as hives, swelling, anaphylaxis, etc.)
Are you allergic to Latex ❑ Yes ❑ No
Allergies to Medications? ❑ None _____

SOCIAL HISTORY:
Marital Status: _____ How often do you exercise? (days/week, duration, type)
Residency: _____ _____
Alcohol use: ❑ Daily ❑ Socially ❑ Never Tobacco use: ❑ Yes ❑ No

FAMILY HISTORY: (please list diseases that run in your family)

_____
Family history of blood clots: _____ Bleeding disorders: _____

REVIEW OF SYSTEMS:

1. CONSTITUTIONAL ❑ None ❑ Recent weight change ❑ Chills ❑ Fever ❑ Weakness/Fatigue
   GENERAL ❑ _____

2. EYES ❑ None ❑ Vision change ❑ Glasses/Contacts ❑ Cataracts ❑ Glaucoma
   ❑ Other_____

3. EARS, NOSE, THROAT ❑ None ❑ Loss of hearing ❑ Ear ache or infection ❑ Ringing in ear ❑ Hoarseness
   ❑ Other_____

4. CARDIOVASCULAR ❑ None ❑ Chest Pain ❑ Swelling in legs ❑ Shortness in breath ❑ Palpitations
   ❑ Other_____

5. RESPIRATORY ❑ None ❑ Shortness of breath ❑ Wheezing/Asthma ❑ Frequent Cough
   ❑ Other_____

6. GASTROINTESTINAL ❑ None ❑ Heartburn ❑ Acid Reflex ❑ Nausea or vomiting ❑ Abdominal Pain
   ❑ Other_____

7. MUSCULOSKELETAL ❑ None ❑ Arthritis / joint stiffness ❑ Muscle aches ❑ Swelling of joints
   ❑ Other_____

8. SKIN ❑ None ❑ Rash ❑ Ulcers ❑ Abnormal scars ❑ Sores
   ❑ Other_____

9. NEUROLOGICAL ❑ None ❑ Headaches ❑ Fainting/blackouts ❑ Numbness, tingling, loss of sensation in any part of body ❑ Dizziness
   ❑ Other_____

10. PSYCHIATRIC ❑ None ❑ Depression ❑ Nervousness ❑ Anxiety ❑ Mood Swing
    ❑ Other_____

11. ENDOCRINE ❑ None ❑ Excessive thirst or hunger ❑ Hot/cold intolerance ❑ Hot Flashes
    ❑ Other_____

12. HEMATOLOGICAL ❑ None ❑ Easy Bruising ❑ Easy Bleeding ❑ Anemia
    ❑ Other_____

Signature:_____ Date:_____

Name:_____