Orthopedics New England
Dedication. Compassion. Experience.

HEALTH ASSESSMENT QUESTIONNAIRE

Patient Name:_____Today's Date:_____
Patient Address: _____
Phone: Home: _____ Cell: _____
Date of Birth:_____Age:_____Height:_____Weight:_____Occupation:_____
EMAIL ADDRESS:_____ **PRIMARY CARE PHYSICIAN:** _____
PHARMACY NAME AND ADDRESS: _____
Reason for today's visit: _____
Is this **WORK RELATED**: Yes/ No **NAME AND ADDRESS OF EMPLOYER:** _____
AUTO OR PERSONAL Injury: Yes No **OTHER** Injury: Yes No
Description and Date of Injury: _____
_____
Location of pain/problem: _____
Duration of Symptoms: _____
Past Treatment for this problem:_____

Please Check any Of The Following Medical Conditions That Apply:

☐ *HA/VISION CHANGES*	☐ *MI / HEART ATTACK*	☐ *KIDNEY STONES*	☐ *GLAUCOMA/CATARACTS*	☐ *ARRYTHMIA*
☐ *URINARY TRACT INFECTION*	☐ *STROKE/TIA*	☐ *PEPTIC ULCER/REFLUX*	☐ *BLEEDING TENDENCY / COUMADIN*	
☐ *SHORTNESS OF BREATH*	☐ *INFLAMMATORY BOWEL DISEASE*	☐ *HISTORY OF BLOOD CLOT*	☐ *GOUT*	
☐ *COPD*	☐ *HIATAL HERNIA*	☐ *ELEVATED CHOLESTEROL*	☐ *KIDNEY DISEASE*	
☐ *ASTHMA*	☐ *POLYPS*	☐ *SEIZURE/CONVULSION*	☐ *ANEMIA*	
☐ *EMPHYSEMA*	☐ *HIGH BLOOD PRESSURE*	☐ *BOWEL/BLADDER INCONTINENCE*		
☐ *CHEST PAIN / ANGINA*	☐ *DIABETES*	☐ *FEVER / SWEATS / CHILLS*	☐ *PSYCHIATRIC HISTORY*	
☐ *CANCER*	☐ *HEPATITIS*	☐ *FRACTURES*	☐ *OSTEOPOROSIS*	
☐ *TB*	☐ *ARTHRITIS*	☐ *HYPERTHYROIDISM*	☐ *HYPOTHYROIDISM*	

Current Medical Conditions: _____
_____
Current Medications:_____
Past Surgeries:_____
Allergies to Medication:_____
Allergies to Latex: ☐ Yes ☐ No

Social History:

Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed*
Alcohol Use: ☐ *Never* ☐ *Rarely* ☐ *Moderate* ☐ *Daily*
Tobacco Use: ☐ *Yes* ☐ *No* ☐ *Never # Years:*_____*# Packs/Day:*_____*Do you currently smoke?* ☐ *Yes* ☐ *No*
Drug Use: ☐ *Never* *Name of Drug:*_____ *Frequency*_____

Family History: *(Age, Diseases, If deceased cause of death)*

*Father:*_____ *Mother:*_____
*Siblings:*_____
*Children:*_____
*Spouse:*_____

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