

ORTHOPAEDICS NORTHEAST, P.C.

Health Assessment Questionnaire

Patient Name _____

Primary Care Physician (Name) _____

(Address) _____ (Phone) _____

Prescription Medications _____

Other Medications/Dietary/Herbal Supplements _____

Allergies to Medications _____

Medical History

Today's problem _____ Location _____ Left Right

How long? _____ How severe? _____

Past Medical History/Review of Systems

- | | | |
|---|----------------------------------|--|
| <u>Yes</u> <u>No</u> | | <u>Yes</u> <u>No</u> |
| <input type="checkbox"/> <input type="checkbox"/> | Fever, Chills, Headache | <input type="checkbox"/> <input type="checkbox"/> Arthritis or Gout |
| <input type="checkbox"/> <input type="checkbox"/> | Excessive Thirst, Fatigue | <input type="checkbox"/> <input type="checkbox"/> Cancer |
| <input type="checkbox"/> <input type="checkbox"/> | Eye Problems | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> | Ear, Nose, Throat Problems | <input type="checkbox"/> <input type="checkbox"/> Chest Pain/Heart Attack/Arrhythmia |
| <input type="checkbox"/> <input type="checkbox"/> | Breathing Problems | <input type="checkbox"/> <input type="checkbox"/> Hepatitis or HIV |
| <input type="checkbox"/> <input type="checkbox"/> | Stomach Problems/Ulcers | <input type="checkbox"/> <input type="checkbox"/> Seizures/Tremors/Dizziness |
| <input type="checkbox"/> <input type="checkbox"/> | Skin Problems/Rash/Boils | <input type="checkbox"/> <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> <input type="checkbox"/> | Urinary Pain/Frequency/Retention | <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> <input type="checkbox"/> | Diabetes | <input type="checkbox"/> <input type="checkbox"/> Hereditary Defects |
| <input type="checkbox"/> <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems |

If "yes" please explain _____

Previous surgery _____

Any other medical problems _____

Social History

- Marital Status Single Married Divorced Widowed
- Alcohol Use Never Rarely Moderate Daily
- Tobacco Use Never Stopped Currently How Long? _____ How Much? _____
- Drug Use Never Type/Frequency _____

Family History (Ages, Diseases, If deceased age and cause of death)

Father _____

Mother _____

Siblings _____

Spouse _____

Children _____

Patient's Signature _____ Date _____