ESSEX ORTHOPAEDICS & OPTIMA SPORTS MEDICINE
16 Pelham Rd. Salem, NH 03079 (603) 898-2244

Name:_____ **Date:**_____ **Page 1/3**
Chief Complaint (reason for visit):_____

Primary Care Physician:_____ **Referring Physician:**_____
Height:_____ **Weight:**_____

Past Medical History (please mark Yes or No for each item)

Yes	No		Yes	No	
____	____	Ambulatory Support (Walker, Cane, Prosthesis)	____	____	Infections
____	____	Anemia	____	____	Kidney Disease
____	____	Anxiety Disorder	____	____	Leg or Foot Ulcers
____	____	Arthritis	____	____	Liver Disease
____	____	Asthma/ Breathing Problems	____	____	Lower Extremity Fracture
____	____	Balanced Problems	____	____	Lung Disease
____	____	Bleeding Disorder- Incl. Blood Thinner	____	____	Migraines
____	____	Blood Clots	____	____	Neurological (Incl. Parkinson's, MS)
____	____	Cancer	____	____	Osteoporosis
____	____	Cataracts	____	____	Pacemaker
____	____	Coronary Artery Disease	____	____	Peripheral Vascular Disease
____	____	CRPS - Complex Regional Pain Syndr	____	____	Pulmonary Embolism
____	____	Dementia - Including Alzheimer's	____	____	Rheumatoid Arthritis
____	____	Depression	____	____	Seizures/Epilepsy
____	____	Diabetes	____	____	Skin Problems
____	____	GERD/Reflux	____	____	Spine Fracture
____	____	Gout	____	____	Steroid Use - Current/Past
____	____	Heart Attack (MI)	____	____	Stroke
____	____	Heart Problems (Incl. Atrial Fibrillation)	____	____	Thyroid Problems
____	____	Hepatitis	____	____	Ulcers
____	____	Hernia	____	____	Upper Extremity Fracture
____	____	HIV or AIDS	____	____	Urinary Tract Infection
____	____	Hypertension			

Previous Surgery (□ check if none) **When** **Where** **Surgeon**

_____
_____
_____
_____
_____
_____
_____
_____

Medications (include dose and how often you take it)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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Allergies:_____
(□ check here if no allergies)

Review of Systems (please circle the relevant items on each line)

Constitutional
fever night sweats weight gain (___lbs) weight loss (___ lbs) exercise intolerance **none**

Eyes
dry eyes irritation vision change **none**

Ears
difficulty hearing ear pain **none**

Nose
frequent nosebleeds nose/sinus problems **none**

Mouth/Throat
sore throat bleeding gums snoring dry mouth oral abnormalities mouth ulcer
teeth abnormalities mouth breathing **none**

Cardiovascular
chest pain on exertion arm pain on exertion shortness of breath when walking
shortness of breath when lying down palpitations known heart murmur light-headed on standing
none

Respiratory
cough wheezing shortness of breath coughing up blood sleep apnea **none**

Gastrointestinal
abdominal pain vomiting change in appetite black or tarry stools frequent diarrhea
vomiting blood **none**

Genitourinary
urinary loss of control difficulty urinating increased urinary frequency hematuria
incomplete emptying **none**

Musculoskeletal
muscle aches muscle weakness arthralgias/joint pain back pain swelling in the extremities
none

Integumentary
abnormal mole jaundice rash itching dry skin growths/lesions **none**

Neurologic
loss of consciousness weakness numbness seizures dizziness frequent or severe headaches
migraines restless legs **none**

Psychiatric
depression sleep disturbances restless sleep feeling unsafe in relationship alcohol abuse **none**

Endocrine
fatigue increased thirst hair loss increased hair growth cold intolerance **none**

Hematologic/Lymphatic
easy bruising excessive bleeding **none**

Allergic/Immunologic
runny nose sinus pressure itching hives frequent sneezing **none**

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Social History

Marital status: Married Single Divorced Separated Widowed Domestic partner
Live alone or with others? Alone With others
Number of children: _____
Children under 26: _____
Single or multi level home? Single level home Multi level home
Are you currently employed? Yes No
Occupation:_____
Employer:_____
Hand Dominance: Right Left Bilateral
Smoking Status: Never smoker Former smoker Current every day smoker Current some day smoker
Smoking - How much? None 1 PPW 2 PPW 1/4 PPD 1/2 PPD 1 PPD 1 1/2 PPD 2 PPD 3+ PPD
Have smoked since age:_____
If former smoker when did you quit?_____
Cigars: Yes No
Chewing tobacco: none 1/day 2-4/day 5+/day
Alcohol intake: None Occasional Moderate Heavy Notes
Drug Use: Prescription Narcotics: Yes No
Drug Use: Recreational: Yes No
Exercise level: None Occasional Moderate Heavy
Sporting activities:_____
Work related injury? Yes No
Auto related injury? Yes No
If injured, is litigation ongoing? Yes No
Advance directive (Living Will, Durable Power of Attorney): Yes No

Family History: (circle and identify mother, father, sibling, maternal or paternal grandparent)

Arthritis
Asthma
Back Problems
Bleeding Disorders
Cancer
Diabetes
Gout
Heart Attack (MI)
Heart Problem
High Cholesterol
Hypertension
Orthopaedic Problems
Osteoarthritis
Osteoporosis
Other
Pulmonary Embolism
Rheumatoid Arthritis
Stroke