

ESSEX ORTHOPAEDICS & OPTIMA SPORTS MEDICINE

16 PELHAM ROAD, SUITE 1

SALEM, NH 03079

603 - 898 - 2244

Name: _____ Date: _____

Please fill in the detailed medical information below as completely as possible. The information is important to us, in order to provide you with the best possible care.

Chief Complaint/The problem for which you need care:

What Caused This? _____ When? _____ Work Injury?: Yes No

Have you seen another physician or provider? Yes No Provider Name?: _____

Name of Primary Care Physician? _____

Do You Have Any Of The Following Medical Problems? Please explain each in the space below.

| Yes | No | | Yes | No | |
|-----|-----|--|-----|-----|--------------------------------------|
| ___ | ___ | Anxiety And/Or Depression | ___ | ___ | Immune Disorder |
| ___ | ___ | Arthritis | ___ | ___ | Renal Disease |
| ___ | ___ | Asthma/Respiratory Problems | ___ | ___ | (Kidney Failure, Dialysis, Stones) |
| ___ | ___ | Blood Clots/Phlebitis or Embolism | ___ | ___ | Liver Disease |
| ___ | ___ | Blood Disorders | ___ | ___ | (Jaundice, Cirrhosis, Hepatitis) |
| ___ | ___ | Cancer | ___ | ___ | Nausea/Vomiting/Indigestion |
| ___ | ___ | Cardiac (Heart) Problems | ___ | ___ | Numbness |
| ___ | ___ | Chest Pain | ___ | ___ | Shaking/Tremors |
| ___ | ___ | Circulation Problems | ___ | ___ | Shortness of Breath |
| ___ | ___ | Cold Hands Or Feet | ___ | ___ | Sleep Disturbance |
| ___ | ___ | Cough | ___ | ___ | Steroids For Medical Treatment |
| ___ | ___ | Diabetes | ___ | ___ | Steroids For Muscle Building |
| ___ | ___ | Fainting/Dizziness | ___ | ___ | Swelling Of Legs (Not Due To Injury) |
| ___ | ___ | Fractures | ___ | ___ | Radiation Exposure |
| ___ | ___ | Frequent Falls | ___ | ___ | Thyroid Problems |
| ___ | ___ | Frequent Headaches | ___ | ___ | Urinary Problems |
| ___ | ___ | Gastro-Intestinal Disease | ___ | ___ | (Incontinence, Infections) |
| ___ | ___ | (Blood In Stool, Bowel Disease, Ulcers | ___ | ___ | Vascular Problems (Vessels) |
| ___ | ___ | Hiatal Hernia, Incontinence) | ___ | ___ | Weakness |
| ___ | ___ | Hormonal Problem | ___ | ___ | Weight Disorder |
| ___ | ___ | Hypertension (High Blood Pressure) | ___ | ___ | (Obesity, Anorexia, Bulimia, etc) |
| ___ | ___ | Infections (Any Type) | ___ | ___ | Weight Loss or Gain |

Please explain any YES answers noted above:

(Please Continue To Page 2)

Name: _____ Date: _____

Your Occupation (current, past): _____

Your Marital Status: Single Married Divorced Other

Children? No Yes: What Are Their Ages: _____

Are You Allergic To Medications? Yes No

Please List All Allergies: _____

Please List Medications and Supplements, Both Prescription and Non-Prescription

Drug Dose How Often? Drug Dose How Often?

| | | | | | |
|-------|-------|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Have you had surgery previously?

Procedure Surgeon Hospital? When?

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Do You Use Tobacco Now? Yes No

Have You Used Tobacco In The Past? Yes No

What Product(s): _____ How Much/How Long? _____

Do You Drink Alcohol? Yes No

How Much/How Often? _____

Your Height? _____ Your Weight? _____ Weight @ Age 18? _____

Is There A Family History of Medical Problems? Please give details.
(arthritis, heart disease, lung disease, diabetes, hypertension, congenital problems, etc.)

Office Use Only:

Date/Weight/Height: _____

Dates Reviewed: _____

| | | | | | |
|-------|-------|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |