NORTH COUNTRY
ORTHOPAEDIC GROUP ™

Health Survey

Name:_____ DOB: ____/____/____ Today's Date: ____/____/____

Signature: _____ Occupation: _____

CURRENT MEDICATIONS (prescription and over-the-counter): *(please include dosage and frequency)*

ALLERGIES TO MEDICATIONS:

PREVIOUS SURGERIES:

MEDICAL CONDITIONS: (*please circle if you have any of these conditions)*

Diabetes	Lung Problems	High Cholesterol	History of Stroke
High Blood Pressure	Liver Problems	Thyroid Problems	or Heart Attack
Heart Disease	Kidney Problems	Anxiety or Depression	Other

FAMILY HISTORY: *(please check all that apply)*

	Arthritis	Diabetes	High Blood Pressure	Cancer	Heart Disease	High Cholesterol	Thyroid or Pituitary Disease
Father							
Mother							

SOCIAL HISTORY: (*please circle)*

Do you smoke? Yes or No Have you ever? Yes or No How much? _____

Do you use alcohol? Yes or No If yes, how often: Daily Occasionally Rarely

REVIEW OF SYSTEMS: (*Circle if you have any of these conditions)*

Constitutional Symptoms	Genitourinary	Musculoskeletal	Allergic/Immunologic	Neurological
Fever	Urinary Incontinence	Pain	Latex Allergy	Speech Problems
Weight Loss	Burning	Swelling	Environmental Allergy	Swallowing Problems
Malaise	Hesitance	Stiffness	Hay Fever	Sensation Problems
Gastrointestinal	**Cardiovascular**	**Respiratory**	**Hematologic/Lymphatic**	Seizures
Weight Loss	Palpitations	Shortness of Breath	Bleeding Tendency	Visual Changes
Weight Gain	Chest Pain	Cough	Lymph Node Enlargement	Balance

Skin	Psychiatric	Endocrine
Rashes	Depression	Appetite Changes
Open sores	Anxiety	Hair Changes

PAIN SCALE: What is your pain level today? (*1-10, 10 being the worst pain*) _____