

Heartland Hand & Spine Orthopaedic Center, P.A.

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HISTORY AND PHYSICAL

Name: _____ Date of Birth _____ Sex _____

Age _____ Height _____ Weight _____ Right or Left-Handed _____

Complaint: _____

Date of Injury or Onset of Illness: _____

Previous Test(s): (Circle all that apply) X-Ray MRI EMG CT Scan Other _____

PAST MEDICAL HISTORY

Are you now or have you ever been treated for any of the following:

	<u>Yes</u>	<u>No</u>	<u>Explain:</u>
Diabetes	___	___	_____
Cancer	___	___	_____
Heart Problems	___	___	_____
Chest Pain	___	___	_____
Asthma	___	___	_____
Epilepsy/Seizure	___	___	_____
Stroke	___	___	_____
Thyroid	___	___	_____
Bleeding Disorder	___	___	_____
Hepatitis	___	___	_____
Jaundice	___	___	_____
AIDS/HIV	___	___	_____

FEMALES ONLY

(next 2 questions)

Could you be pregnant? YES _____ NO _____

Date of last menstrual period: _____

Are you allergic to any medicine, tapes or iodine? If yes, please list: _____

Are you currently taking any medications? If yes, please list: _____

Please list previous surgeries (please include year): _____

	<u>YES</u>	<u>NO</u>	
Do you smoke?	___	___	If yes, how much per day? _____
Do you drink alcohol?	___	___	If yes, how much a week? _____

Name: _____ Date of Birth _____ Sex _____

FAMILY HISTORY:

Is there any family history of health problems such as:

	<u>YES</u>	<u>NO</u>	<u>Explain</u>
Diabetes	_____	_____	_____
Cancer	_____	_____	_____
High Blood Pressure	_____	_____	_____
Stroke	_____	_____	_____
Other	_____	_____	_____

REVIEW OF SYSTEMS

Do you have any complaints with your:

Skin	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Bowels	_____	_____	_____
Bladder	_____	_____	_____
Other	_____	_____	_____

Patient Signature

PHYSICAL EXAM

General Appearance: Age: _____ Sex: _____ Height: _____ Weight: _____

DO NOT WRITE BELOW THIS LINE. TO BE COMPLETED BY PHYSICIAN

HEENT	_____
Neck	_____
Chest	_____
Heart	_____
Lungs	_____
Abdomen	_____
Neuro.	_____
Extrem.	_____
Other	_____

IMPRESSION:

PLAN:

Physician Signature