ORTHOPEDIC ASSOCIATES OF LONG ISLAND
PRECISIONCARE

Today's Date: _____

Dr. Danielle DeGiorgio, DO

Confidential Medical History — Initial visit Intake Form

Name: _____ Date of Birth: _____ Date of Injury: _____

Gender: □Female □Male Dominant Hand: □Right □Left

Home Phone: _____ Cell Phone: _____

Email Address: _____ Referring Provider**:**_____

Injured body part _____ Which side is affected? □Right □Left □Both

How did the injury occur or symptoms begin? _____

_____

What is the status of your symptoms, e.g., stable, improving, worsening? _____

When are your symptoms most severe, e.g., morning, evening, at night? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Rate your pain on a scale of 0 (no pain) to 10 (extreme pain): Right now: ___ At best: ___ At worst: ___

What is the quality of your pain, e.g., sharp, dull, burning? _____

Is the pain constant or intermittent? _____

What other symptoms do you have, e.g., stiffness, weakness, popping, swelling, numbness, tingling? ___

_____

Have you seen another physician for your injury/symptoms? □ Yes □No

If yes, who and what was the treatment? _____

Have you experienced anything similar to this in the past? □Yes □No

If yes, please describe: _____

Have you had any of the following tests or treatments for this problem?

Tests	***Date(s) of your tests***	***Treatments***	***Describe treatment – did it help?***
□ X-ray	_____	□ Medications	_____
□ MRI	_____	□ Injections	_____
□ CT scan	_____	□ Surgery	_____
□ Bone scan	_____	□ Physical therapy	_____
□ Ultrasound	_____	□ Bracing	_____
□ Other	_____	□ Other	_____

Patient Name: _____ Date of Birth: _____

Medical History

Please list your medical problems, e.g., high blood pressure, diabetes, high cholesterol, depression, and any condition for which you are prescribed a medication, etc.: _____

_____

Females only – Do you think you might be pregnant at this time? □ Yes □ No

Surgical History

Have you ever had surgery? □ Yes □ No If yes, please describe: _____

_____

Family History

Please list the medical problems of your immediate family, e.g., arthritis, bleeding problems, cancer, diabetes, heart disease, high blood pressure, neurologic problem, osteoporosis, etc.:

Mother: _____

Father: _____

Sibling(s): _____ □ Not applicable

Social History

Marital status: □ Single □ Married □ Partner □ Divorced □ Widowed

Do you have children? □ Yes □ No If yes, how many? _____

Are you currently employed? □ Yes □ No □ Retired

If yes, please list your employer and occupation: _____

Do you use tobacco? □ Yes □ No If yes, how much and how often? _____

Do you use alcohol? □ Yes □ No If yes, how much and how often? _____

Before your current injury/symptoms, please describe your typical physical activity: _____

_____

Are there any upcoming events that may affect your treatment plan, e.g., race, competition, travel?

_____

Medications

Please list your current medications, both prescription and over-the-counter: _____

_____

Please list any supplements that you take regularly: _____

Allergies

What medications are you allergic to? _____

Are you allergic to contrast dyes? □ Yes □ No Are you allergic or sensitive to latex? □ Yes □ No

Patient Name: _____ Date of Birth: _____

Review of Systems

Check any symptom below that you are currently experiencing or have experienced in the past weeks:

Abdominal pain	□ Yes	□ No	Glasses	□ Yes	□ No
Anxiety	□ Yes	□ No	Headache	□ Yes	□ No
Balance problem	□ Yes	□ No	Hearing loss	□ Yes	□ No
Blood in urine	□ Yes	□ No	Hot flashes	□ Yes	□ No
Blurry vision	□ Yes	□ No	Immune system issue	□ Yes	□ No
Bowel incontinence	□ Yes	□ No	Insomnia	□ Yes	□ No
Cellulitis (infection)	□ Yes	□ No	Irregular heartbeat	□ Yes	□ No
Chest pain	□ Yes	□ No	Joint pain	□ Yes	□ No
Cold intolerance	□ Yes	□ No	Joint stiffness	□ Yes	□ No
Constipation	□ Yes	□ No	Muscle aches	□ Yes	□ No
Contacts	□ Yes	□ No	Nose bleeds	□ Yes	□ No
Coordination problem	□ Yes	□ No	Pain with urination	□ Yes	□ No
Cough	□ Yes	□ No	Rash	□ Yes	□ No
Depression	□ Yes	□ No	Ringing in ears	□ Yes	□ No
Diarrhea	□ Yes	□ No	Seasonal allergies	□ Yes	□ No
Double vision	□ Yes	□ No	Seizure	□ Yes	□ No
Easy bleeding	□ Yes	□ No	Shortness of breath	□ Yes	□ No
Easy bruising	□ Yes	□ No	Sore throat	□ Yes	□ No
Eating disorder	□ Yes	□ No	Urinary incontinence	□ Yes	□ No
Excessive thirst	□ Yes	□ No	Weight gain	□ Yes	□ No
Fatigue	□ Yes	□ No	Weight loss	□ Yes	□ No
Fever/chills	□ Yes	□ No	Wheezing	□ Yes	□ No

What goals do you have for today's visit? _____

_____

Is there anything else that you would like your care team to know about you? _____

_____

Would you like today's note to be sent to another physician? □ Yes □ No

If yes, please complete a Medical Release form and provide your doctor's information.
The Medical Release form can be found at the front desk.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____