St.Charles Orthopedics
unparalleled skill | compassionate care

Today's Date: ______________

Danielle DeGiorgio, DO

Confidential Medical History
Initial Visit Intake Form

Patient Name: ____________________ Date of Birth: ______________ Date of Injury: ____________

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

Home/Mobile Phone: ____________________ Work Phone: ____________________

Email Address: ____________________ Referring Doctor: ____________________

Current Problem: ____

Which side is affected? □ Right □ Left □ Both

When did the injury occur or symptoms begin? ______________________________

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 0-10 (0 = no pain, 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, please describe: ______________________________

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 the 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

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

Symptom	Yes	No	Symptom	Yes	No
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 Release of Information form and provide your doctor's information.

Release of Information form can be found at the front desk

Patient Signature: ______________________________ **Date:** ____________________

Physician Signature: ______________________________ **Date:** ____________________