St.Charles Orthopedics
unparalleled skill | compassionate care

Today's Date: ____________

Danielle DeGiorgio, DO

Confidential Medical History
Follow Up Visit Form

Patient Name: ________________________ Date of Birth: ________________

Current Problem: ____

Which side is affected? ☐ Right ☐ Left ☐ Both

How have your symptoms changed since your last visit? ____________________________

____

What have you done to treat your pain since your last visit? ____________________________

____

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 = none, 10 = extreme):

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? ________

____

Medical History

Has there been any change in your medical history, e.g., new diagnoses, recent surgeries or procedures? ________

____

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

Medications

Please list your current medications, both prescription and over-the-counter (name, dose, and frequency): ________

____

____

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			Symptom		
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? ____

____

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:** ________________________