St.Charles Orthopedics
unparalleled skill | compassionate care

Gregory C. Mallo, M.D., FAAOS

New Patient / New Condition Form

NAME: ________________________________ **DOB:**______________________________

OCCUPATION:____

Is the injury work related? □ Yes □ No Date: ________________
Is injury a result of a car accident? □ Yes □ No Date: ________________

Current work status: □ Full time □ Part time □ Homemaker □ Retired □ Disabled □ Not Employed

PLEASE LIST SPORTS OR ACTIVITIES:
____

CHIEF COMPLAINT:□ **Foot** □ **Ankle** □ **Knee** □ **Shoulder** □**Elbow** □**Hip** □**Low back** □ **Neck**

SIDE: □ Right □ Left □ Both

WHICH BEGAN ON: ___ /___ /____ (approximate date or state duration)__________months/years

WHAT TYPE OF INJURY? □ No Specific Injury □ Non-Contact/Twisting Injury □ Contact injury

CURRENT LEVEL OF DISCOMFORT: □ Mild □ Moderate □ Severe | **Pain Level** (1-10):___

THE DISCOMFORT IS: □ Constant □ Intermittent □ Only With Activity □ Sharp □ Dull
AND: □ Getting Better □ Getting Worse □ Unchanged

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS (Check Any That Apply): □ Instability/Giving Way/Buckling □ Dislocation □ Clicking/Popping □ Locking/Catching □Grinding
□ Stiffness □ Pain at Rest □ Night Pain □ Electric/Shooting Pains □ Swelling □Numbness/Tingling

HAVE YOU EVER BEEN TREATED FOR THIS PROBLEM IN THE PAST: □ **Yes** □ **No**
IF YES, WHAT TREATMENTS HAVE YOU TRIED?
□ None □ Ice □ Heat □ Activity Modification □ Injections □ Orthotics
□ Cast □ Rest □ ER Visit □ Physical Therapy □ MRI □ Cat_Scan □ Bone Scan
□ EMG/Nerve Study
□ Bracing (type)_________________________ □ Medications___________________________

DATE:________________________________ **Signature:**_____________________________