PATIENT INFORMATION	
Name:	**Date of Birth:**
Sex :	**Social Security #:**
Address One:	**City:** **State:** **Zip:**
Employer Name:	**Employer Address:**
Home Phone#:	**Work Phone#:**
Cell Phone#:	**Email Address:** ☐ **I give permission for OADC to contact me via email**
Primary Care Physician:	**Pharmacy Name:** **Town:**
Emergency Contact:	**Emergency Phone:**

REASON(s) you are here :_____

On a scale of 0 – 10 (10 being the worst) how severe is your pain? (CIRCLE) 0 1 2 3 4 5 6 7 8 9 10

Height: _____ **Weight:** _____ **Date of Injury:** _____

If 65 or older: ☐ **No falls in the past year**

Please check one: ☐ **One fall without injury in the past year**

☐ **Two or more falls in the past year**

ACTIVE PROBLEM: Please describe your problem.

What body part is involved? ☐ Right ☐ Left (indicate body part) _____

How long ago did the problem begin? _____

Where were you injured: ☐ Auto ☐ Work ☐ Sports ☐ Home ☐ Other:_____

Quality of the pain is: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes and goes (intermittent)

Do you have: ☐ Swelling ☐ Bruising ☐ Locking ☐ Catching ☐ Giving way weakness

☐ Numbness ☐ Tingling Weakness ☐ Loss of bowel or bladder function

What makes your symptoms better? ☐ Rest ☐ Elevation ☐ Ice/Heat ☐ Other:_____

What makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Lying down

☐ Kneeling ☐ Sitting ☐ Twisting ☐ Stairs ☐ Coughing

Since this problem started, it is: ☐ Getting better ☐ Getting Worse ☐ Unchanged

PAST MEDICAL HISTORY (Part I): Please place a checkmark (√) if you currently have or have had any of the following conditions:

	Active Bleeding or Anemia		Dialysis
	Active/Recent Liver Disease (Hepatitis B/C, cirrhosis)		Heart Attack
	ANY Heart Surgery		High Blood Pressure
	Atrial Fibrillation		Hospitalization for poorly controlled diabetes
	Bleeding/Clotting Disorder Managed by Physician		Neuromuscular Disease (i.e. Myasthenia Gravis, ALS)
	Chronic Kidney Disease (other than stones)		Pacemaker/Implanted Defibrillator
	Congestive Heart Failure		Pneumonia in PAST 6 MONTHS
	COPD requiring HOSPITALIZATION IN PAST YEAR		Problem with Heart Valves (other than mitral valve prolapse)
	COPD requiring HOME OXYGEN		Seizure in the PAST 6 MONTHS
	Coronary Artery Disease/Stents		Sleep Apnea
	Deep Vein Thrombosis of Lower Extremities		Stroke (or Brain Surgery) in the past month
	Diabetes		Taking Warfarin (Coumadin)

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PAST MEDICAL HISTORY (Part II): Please place a checkmark (√) if you currently have or have had any of the following conditions:

	Asthma/Bronchitis		Fractures :		Pancreatitis
	Bladder Infection/UTI		Glaucoma		Pulmonary Embolism
	Bloody Stools-Red Blood in Bowel Movement		Gout		Psychiatric Disorder
	Cancer/Leukemia		Heart Arrhythmia/Sinus		Reflux
	Cellulitis		Hepatitis		Rheumatoid Arthritis
	Elevated Cholesterol		HIV		Stomach Ulcers/Gastric
	Bleeding Ulcer-Esoph Ulcer w/hemorrhage		Lyme Disease		Thyroid Disorder
	Epilepsy				Osteoporosis
					Other (Please explain):

PAST SURGICAL HISTORY/PROCEDURE: (Please list all surgical procedures and dates performed)

_____

_____

FAMILY HISTORY: Do any of your immediate family members have any of the following conditions?

Conditions	Father	Mother	Brother	Sister	Son	Daughter	Relative Other:	Relative Other:
Heart Attack								
Diabetes								
Osteoarthritis								
Asthma								
Emphysema								
Rheumatoid Arthritis								
Cancer								
Glaucoma								
CAD								
Lower Back Pain								
Sickle Cell Anemia								
Depression								
Neck Pain								
Thyroid Disorder								
Other:								

SOCIAL HISTORY

Are you currently working? ☐ Yes ☐ No

Occupation:_____ Employer: _____

Where do you live? ☐ Home ☐ Apartment ☐ Retirement Community ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you adopted: ☐ Yes ☐ No

Do you use tobacco: ☐ Yes ☐ Former ☐ Never

Do you use alcohol: ☐ Never ☐ Occasional ☐ Daily ☐ Heavy ☐ History of Alcoholism

Any history of drug use: ☐ Yes ☐ No

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ALLERGIES:

Are you allergic to any medications: Yes No If yes please list: _____

_____

_____

Are you allergic to foods, metals or jewelry? ☐ Yes ☐ No If yes please list: _____

_____

_____

Are you allergic to Latex? ☐ Yes ☐ No

MEDICATION HISTORY:

Medication	Dose	How Often	Medication	Dose	How Often

IMMUNIZATIONS:

Flu Shot ☐ Yes ☐ No Date:_____
Pneumo ☐ Yes ☐ No Date:_____
Anti-inflammatory medications (ie Motrin, Aleve) ☐ Yes ☐ No Date started:_____
Physical Therapy/Home exercise program ☐Yes ☐No Date started:_____

Review of Systems: (Please check all that apply)

Patient's review of systems (Circle the ones that apply to you)

Eyes: Eyeglasses Cataracts Glaucoma Other:
Skin: Rashes Dermatitis Psoriasis Eczema Other:
Ear/Nose Throat: Deafness Allergies Sinus Trouble Nosebleeds Chronic Sinus Infections Difficulty Swallowing Other:
Neurologic: Stroke Dizziness Numbness Fainting Seizure Multiple Sclerosis Parkinson's Blackout/Falls Other:
Infectious Disease: HIV/AIDS Hepatitis Lyme Disease Post TB Test Other:
Heart and Cardiovascular: Chest Pain Heart Disease Blood Clots Rheumatic Fever Heart Attack Hypertension Arrhythmia Murmurs Palpitations Hypotension Varicose Veins PE (pulmonary embolism) Circulation Problems Other:
Endocrine: Diabetes Mellitus Thyroid Disease Other:

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Genitourinary: Bladder Disorders Infections of a Kidney Dysuria Renal Disease Kidney Stone Analysis Nocturia Bladder Incontinence Frequent Urination Prostate Problem Other:
Pulmonary/Respiratory: Asthma Emphysema Bronchitis Pneumonia Wheezing SOB (shortness of breath) Apnea COPD Other:
Hematological/Lymphatic: Lymphedema Easy Bleeding Easy Bruising Anemia Blood Transfusion Hematologic Disorder Sickle Cell Other:
Psychologic: Depression Anxiety Bipolar Disorder Other:
Gastrointestinal: Ulcer Nausea Constipation Liver Disease Reflux Vomiting Bloody/Black Stool Jaundice Crohn's Diarrhea Abdominal Pain Other:
Constitutional: Fever Anorexia Night Sweats Chills Weight Loss Fatigue Other:
Oncologic: Breast Cancer Kidney Cancer Lung Cancer Colon Cancer Liver Cancer Prostate Cancer Skin Cancer Other:
Musculoskeletal: Rheumatoid Back Pain Slipped Disc Joint Pain Neck Pain Leg Pain Gout Osteoporosis Other:

ACKNOWLEDGEMENT OF PRESCRIPTION ACCESS

I agree that Orthopedic Associates of Dutchess County, P.C. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Initials _____

Pharmacy: _____City/Town: _____Ph#_____

Your patient information may be used to contact you by telephone/mail for the purpose of treatment, payment or health care operations. If you have any restrictions for communication with you please let us know on this line. _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices Policy. I have read (or have the opportunity to read if I choose) and understand the notices.

_____
Patient Name (Please Print)

_____
Parent or Authorized Representative

_____
Signature

_____
Date

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