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** ☐ **One fall without injury in the past year**

Please check one: ☐ **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? _____

Prior Pain/Injury to same body part? ☐ Yes ☐ No (what/when)_____

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

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		Parkinson's
	Bloody Stools-Red Blood in Bowel Movement		Gout		Pulmonary Embolism
	Blood Transfusion		Heart Arrhythmia/Sinus		Pneumonia
	Bleeding Ulcer-Esoph Ulcer w/hemorrhage		Hepatitis		Psychiatric Disorder
	Crohn's		HIV		Reflux
	Cancer		Kidney Stones/Renal Disease		Rheumatoid Arthritis
	Depression		Leukemia		Sickle Cell
	Elevated Cholesterol		Liver Disease		Stomach Ulcers
	Epilepsy		Lyme Disease		(+) TB test
			Multiple Sclerosis		Thyroid Disorder: Hyper or Hypo
			Obesity		

HOSPITALIZATION IN THE LAST YEAR: _____

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?

☐ Adopted or unknown

Conditions	Father	Mother	Siblings	Children	Other:
Heart Attack					
Diabetes					
Osteoarthritis					
Asthma					
Rheumatoid Arthritis					
Cancer					
Glaucoma					
DVT/PE					
Lower Back Pain					
Bleeding or clotting disorder					
Other:					

SOCIAL HISTORY

Are you currently working? ☐ Yes ☐ No

Occupation:_____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you use tobacco: ☐ Yes ☐ Former ☐ Never

Do you use a nicotine product? ☐ Yes ☐ Former ☐ Never Describe:_____

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

Any history of recreational or illegal drug use: ☐ Yes ☐ No If yes, last time used:_____

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

Anti-inflammatory medications (ie Motrin, Aleve) ☐ Yes ☐ No Date started:_____

Physical Therapy/Home exercise program ☐Yes ☐No Date started:_____

IMMUNIZATIONS:

Flu Shot ☐ Yes ☐ No Date:_____

Tetanus ☐ Yes ☐ No Date:_____

Review of Systems: (Please check all that apply)

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

Eyes :	Eyeglasses Cataracts Glaucoma Contacts 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 Headaches Blackout/Falls Other:
Infectious Disease:	HIV Infection Hepatitis Lyme Disease Other:
Heart & 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:	Thyroid Excessive Hunger or Thirst Excessive Sweating Diabetes Other:
Genitourinary:	Frequent Urination Burning or Pain Hematuria Prostate Problem Bladder Incontinence Other:
Pulmonary/Respiratory:	Emphysema Wheezing SOB (Shortness Of Breath) Sleep Apnea COPD Other:
Hematological/Lymphatic:	Lymphedema Easy Bleeding Easy Bruising Hematologic Disorder Other:

Psychologic: Mood Changes Sad or Feeling Down Confused Depression Anxiety Other:
Gastrointestinal: Bloating Nausea Constipation Reflux Vomiting Jaundice Abdominal Pain Other:
Constitutional: Fever Anorexia Night Sweats Chills Weight Loss Fatigue Other:
OBGYN: ☐ Pregnant ☐ Ovarian Cancer ☐Cysts ☐ Endometriosis Other:
Musculoskeletal: Rheumatoid Back Pain Muscle Pain Joint Pain Neck Pain Leg Pain Gout Osteoporosis Weakness Other:
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