Orthopedic Associates
of Dutchess County
www.orthoadc.com

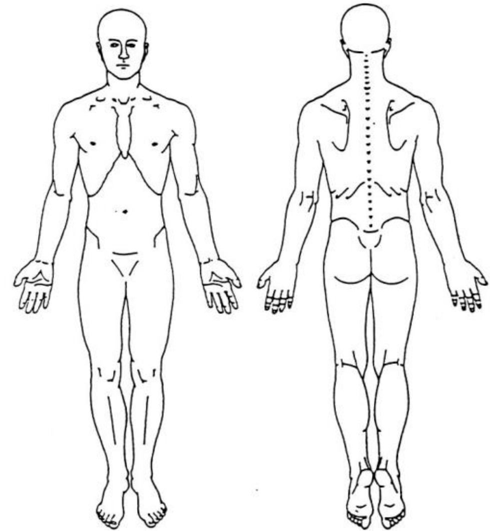
Name:________________________ Date:_________ Date of Birth:_______________ Today's Date:___/___/_____

Main Problem(s) Today:

1. ______________________________________

2. ______________________________________

3. ______________________________________



Describe your pain (circle all that apply):
Sharp, Stabbing, pinching, piercing, grabbing, aching, throbbing, shooting, burning, numbness, tingling, other:______________________________________

Circle pain level today:
1 2 3 4 5 6 7 8 9 10

What makes your pain worse:
____

What makes your pain better:
____

Did you recently receive an injection since our last encounter?
☐Yes ☐No, if yes what percent relief from your usual pain did you receive? _________%

Functional capacity:
How far can you walk: ___________
Does your pain affect your ability to:

Bath yourself	YES	NO
Cook	YES	NO
Clean your house	YES	NO
Dress yourself	YES	NO
Sleep	YES	NO

Please list all pain medications being taken presently:
____
____

(Please turn over)

Patient's review of systems (Circle all 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:	

Patient Signature:____ Date:______________________