ORTHOPEDIC ASSOCIATES OF LONG ISLAND
PRECISIONCARE

Today's Date: _____

Dr. Danielle DeGiorgio, DO

Confidential Medical History — Follow Form

Name: _____ Date of Birth: _____

Current Problem:

Injured body part: _____ Which side is affected? □ Right □ Left

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 (no pain) to 10 (extreme pain):

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

Please list your medical problems, e.g., high blood pressure, diabetes, high cholesterol, depression, and any condition for which you are prescribed a medication, etc.: _____

_____

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: _____

_____

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

Check any symptom below that you are currently experiencing or have experienced in the past weeks:

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 Medical Release form and provide your doctor's information.
The Medical Release form can be found at the front desk.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____