ESTABLISHED PATIENT HISTORY – J. DELGADO, M.D.

For office staff:	
Weight:	BP:
Height:	HR:

Appointment Date: _____ **DOB:** _____**Age:** _____

Patient Name: _____ **Primary Care Physician**: _____

1. **Reason for visit:** ☐ follow up Visit ☐ f/u Fracture care ☐ Post-op: Surgery_____ Date_____ ☐ Other:
2. **What body part and side are involved?**

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L

3. Is there a new problem that was not evaluated at your last visit? ☐ Y ☐ N If yes, what is it? _____
4. Since your last visit, are you: ☐ better ☐ worse ☐ same
5. On a scale of 0–100%, how much better are you now? (0%=not better) _____%
6. On a scale of 0–10 (10 is the worst) how severe is your pain at its worst? (circle, choose range) 0 1 2 3 4 5 6 7 8 9 10
7. What is the quality of the pain? ☐ sharp ☐dull ☐ stabbing ☐ throbbing ☐ aching ☐ burning
8. The pain is now: ☐ constant ☐ comes and goes (intermittent). Does your pain wake you from your sleep? ☐ Y ☐ N
9. Do you have (additional symptoms): ❑ swelling ❑ bruises ❑ numbness ❑ tingling ❑ weakness ❑locking/catching ❑ giving way ❑ fevers/chills ❑ abrasions/lacerations/wounds ❑ gait difficulty
10. What medications are you **still taking** for this condition: ☐None ☐ Anti-Inflammatory _____ (name)
    ☐ Narcotic pain killer _____ (name)
11. Use check box below to show what treatment was done since your last visit:

Treatment	**Did it help?**
☐ Anti-inflammatories	☐ Y ☐ N
☐ Narcotics	☐ Y ☐ N
☐ Brace/Cast	☐ Y ☐ N
☐ Physical/Occupational Therapy	☐ Y ☐ N
☐ Home Exercise Program	☐ Y ☐ N
☐ Cane/Crutches/Walker	☐ Y ☐ N
☐ Injection at last visit	☐ Y ☐ N
☐ Surgery since last visit	☐ Y ☐ N

Interval history: Since the last visit, have you:

*ROS •Developed new problems in:
Eyes ☐ Y ☐ N Heart ☐ Y ☐ N Bowels ☐ Y ☐ N Skin ☐ Y ☐ N
Ears ☐ Y ☐ N Lungs ☐ Y ☐ N Urine ☐ Y ☐ N Diabetes ☐ Y ☐ N
Nerves ☐ Y ☐ N Joints ☐ Y ☐ N None ☐ Y ☐ N General (fevers) ☐ Y ☐ N

•Please describe any new problems: _____

•Developed new allergies? ☐ Y ☐ N If yes, please describe_____

*PMH •Been prescribed new medications by any other physician? ☐ Y ☐ N If Yes, please describe: _____

•Been hospitalized for a non-orthopedic condition? ☐ Y ☐ N If yes, please describe: _____

*SH •Started or stopped smoking ☐ Y ☐ N If yes, please describe: _____

•What is your current job status? ☐ regular job ☐ light duty ☐ not working due to this condition ☐ do not work

*Medications:_____

*Drug Allergies: _____

Are there any questions you want the doctor to answer for you this visit? _____

_____

Patient Signature_____ Date_____

MD Signature_____ Date_____