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First State Orthopaedics
4745 Ogletown-Stanton Road, Suite 225
Newark, DE 19713

Treating FSO Physician/PA/NP _____

PATIENT INFORMATION

Name: **Age:** **DOB:** **FSO MRN:**

Body Part: **Complaint:** ☐ Pain ☐ Injury ☐ Fracture ☐ Numbness ☐ Swelling ☐ Other

Previous Treating Doctor for this Problem? **Did that doctor refer you here?** ☐ Yes ☐ No

HISTORY OF PRESENT INJURY

Diagnostic Tests/Treatment Performed: ☐X-ray ☐MRI ☐CT Scan ☐Injection ☐NSAID's ☐EMG ☐Bone Scan ☐Lab Work ☐PT
Have you ever had similar problem? If yes, please give details: _____
Onset/Date of Injury: _____

Severity
☐ Mild
☐ Mild-Moderate
☐ Moderate
☐ Moderate-Severe
☐ Severe

Frequency
☐ Intermittent
☐ Occasional
☐ Constant
☐ Rare

Quality
☐ Achy
☐ Burning
☐ Dull
☐ Piercing
☐ Sharp
☐ Throbbing

Aggravated By
☐ Bending
☐ Climbing Stairs
☐ Lifting
☐ Movement
☐ Pushing
☐ Sitting
☐ Standing
☐ Walking
☐ Other:_____

Associated Symptoms
☐ Bruising
☐ Crepitus (Cracking Sounds)
☐ Decreased Mobility
☐ Difficulty going to sleep
☐ Instability
☐ Limping
☐ Other: _____

☐ Numbness
☐ Popping
☐ Spasms
☐ Swelling
☐ Tenderness
☐ Locking
☐ Night Pain
☐ Tingling in arms
☐ Tingling in legs

PATIENT'S MEDICAL CONDITION

Height: ____ ft ____ in Weight: ____ lbs Blood Pressure: ____/____ List details of any diet program: _____
My Weight in the last 6 months has: ☐ Not Changed ☐ Increased _____ lbs. ☐ Decreased _____ lbs.
Have you ever taken any anti-inflammatories/arthritis medications? ☐ Yes ☐ No (Ex: Naprosyn/Ibuprofen) If yes, please list:
_____

PATIENT'S FAMILY/SOCIAL HISTORY

Do you smoke: ☐ Yes ☐ No ☐ Former/Year Quit _____ Consume Alcohol: ☐ Yes ☐ No ☐ Former/Year Quit
Type of Exercise: _____ Activity Level: ☐ Sedentary ☐ Moderate ☐ Vigorous
History of Addiction or Substance Abuse?: _____
Is your Father Living?: ☐ Yes ☐ No If no, age deceased _____ cause of death _____
Is your Mother Living?: ☐ Yes ☐ No If no, age deceased _____ cause of death _____
Are any of your brothers/sisters deceased? ☐ Yes ☐ No If yes, age deceased _____ cause of death _____
Family history of chronic/inherited diseases: _____

PATIENT'S MEDICAL HISTORY

☐ AIDS/HIV
☐ Alcoholism
☐ Asthma
☐ Atrial Fibrillation
☐ Cancer_____
☐ Congestive Heart Failure
☐ COPD (Emphysema
☐ Coronary Artery Disease
☐ Diabetes
Last Hemoglobin A1c _____
Date: _____

☐ Drug Abuse
☐ DVT (Blood Clots)
☐ Gallbladder Disease
☐ GERD
☐ Gout
☐ Hepatitis/Liver Disease
☐ High Cholesterol
☐ High Blood Pressure
☐ Hyperthyroidism (overactive)
☐ Hypothyroidism (underactive)

☐ Inflammatory Bowel Disease
☐ Lyme Disease
☐ Myocardial Infarction
☐ Parkinson's Disease
☐ Peptic Ulcer Disease
☐ Renal Disease
☐ Scoliosis
☐ Seizure Disorder
☐ Sleep Apnea
☐ Stroke (Cerebrovascular Accident)

☐ Spinal Stenosis
☐ Thyroid Disease
☐ Valvular Disease (Heart Valve Problems)
☐ Other:_____
_____
_____
☐Last Pneumonia Shot
_____

PATIENT'S SURGICAL HISTORY

Year/Date	Type of Surgery	Name of Surgeon

Pharmacy Name: _____ Pharmacy Address: _____ Pharmacy Phone Number: _____

PRESCRIPTION MEDICATIONS - PLEASE ATTACH LIST IF APPLICABLE		
Name the Medication	Strength	Frequency Taken
Please list any over the counter medications including any supplements or vitamins (Advil, Tylenol, Motrin, Prevacid, Zyrtec)		
Name the Medication	Strength	Frequency Taken
ALLERGIES – PLEASE ATTACH LIST IF APPLICABLE		
Name of Medication	Reaction You Had	
SIGNATURE		
Date:	Signature of Patient, Parent, or Guardian:	
NOTES/COMMENTS (CLINICAL USE ONLY)		