Bone & Joint Clinic
TEXAS HEALTH CARE FORT WORTH

NEW PROBLEM INFORMATION

Please answer all questions on both pages
Circle answers where indicated

This space for office use only

Name: ______________________ Age: ________ Today's Date: ____________

Have you been referred to Dr. Dolce by another doctor? Yes / No If yes, who? ____________

If not, how did you hear about Dr. Dolce? I'm a previous Dr. Dolce patient / insurance company

My family has seen Dr. Dolce / I'm a patient of the Bone & Joint Clinic / Internet / Friend

Bone & Joint Clinic website / athletic trainer / other: ____________

Is this injury / problem work related? Yes / No

What sports do you play? ______________________ What School? ____________

WHAT problem brings you to the office today / What hurts? ____________

WHEN were you injured / How long have you had this problem? ____________

HOW did the injury / problem occur? (gradual onset, fall, accident, etc.) ____________

____

DESCRIBE your pain (circle all that apply): Sharp / Stabbing / Dull / Aching / Numb / Tingling

Burning / Pins + Needles / Popping / Locking / Instability / Swelling / Limping / Constant / Intermittent

Other: ____

RATE your usual pain from this problem on a scale of 1 to 10 (10 being the worst): ____________

What makes your pain WORSE: Walking / Standing / Sitting / Car rides / Sports / Running / Twisting

Lifting / Bending / Overhead activity / Reaching back / Pivoting / Bed Time / Stair climbing

Getting up out of a chair / Other: ______________________________

What ***TREATMENT*** have you had for this problem? None / Tylenol / Advil / Ice / Physical Therapy

Injections / Surgery / Chiropractic Other: ______________________________

Did it help? Yes / No / Stayed the same / Made it worse

Circle one; Is the pain: getting better / getting worse / staying the same.

Have you ever injured this body part in the past? Yes / No explain: ____________

Nurse: ____________ Room: ____________

Height: ____________ Weight: ____________ BP: ____________

Smoking History: Circle one: Never have smoked / Current everyday smoker / Current some day smoker / Former Smoker
How much do you smoke per day? ______________________
Age began smoking: __________ Age stopped smoking: ______________
Do you drink alcohol? Yes / No / Former drinker / Year quit? ______________

Are you currently experiencing any of the following? Please circle all that apply.

Fever	Cough	Decreased Appetite	Seizures
Night Sweats	Dysnpea	Heartburn	Anxiety
Hearing Loss	Wheezing	Dysuria	Depression
Vision Loss	Chest Pain	Weight Loss	Insomnia
Asthma	Irregular heart beat	Dizziness	Rash

Please list current and past medical problems: (Diabetes, High blood pressure, etc.) ______________________
____
____
____

What medications do you take on a regular basis? ______________________
____
____
____

Immediate Family History (Parents and Siblings only) Please indicate which family member per diagnosis:

Arthritis	Heart Disease	Diabetes	Renal Disease
Cancer	COPD	Hypertension	Stroke

Are you allergic to any medications, latex, shellfish or Betadine? **Yes / No Please list:** ______________________

Patient Signature: ____

Pharmacy Name: ____
Street Address: ____
Phone# ______________________