Donald Dolce, MD

Fort Worth Orthopedics

Medical History

Date:_____
Room:_____
Height:_____
Weight:_____
BP:_____/_____

Please answer all questions - circle answers where indicated

Name:_____ **Age**:_____ **DOB**:_____

Primary care physician (PCP):_____

Pharmacy:_____Phone#:_____

Pharmacy Address:_____

How did you hear about Dr. Dolce? I am a previous Dr. Dolce Patient / family / friend / social media/ Internet search / our website / athletic trainer / therapist / Insurance company / physician referral: _____

What problem brings you to the office/ what hurts?_____

How did the injury / problem occur?_____

When did the symptoms begin: _____

How long have you had this problem?_____

Have you injured this body part in the past? Yes / No

What IMAGING have you had for this problem? None / X-ray / MRI / CT / EMG

If yes, what facility was imaging done at? _____

Describe your pain / symptoms: sharp / stabbing / dull / aching / numb / tingling / burning / pins & needles / popping / locking / instability / swelling / limping / constant / intermittent / other Please Explain:_____

Rate you usual pain on a scale of 0 to 10 (10 being the worse)_____

Is the pain: improving / worsening / staying the same

What makes your pain worse: walking / sitting / getting up out of a chair / car rides / lifting / sports /running / twisting / bending / over head activity / reaching back / pivoting / sleep / stairs/ other / Explain: _____

What treatment have you had for this problem?None/ Tylenol / advil(NSAIDs) / steroids / Ice / heat / PT / Injections / surgery / chiropractic / airrosti / other: _____

Did the treatment help? Yes/ No / Made it worse

Do you have a pain management doctor? Yes / No

*** Did this injury occur at work?** Yes / No ***Is this an Auto/ Motorcycle accident?** Yes / No

***Is there an attorney involved?** Yes / No

Signature:_____Date:_____

Patient/Guardian if Minor