Duretti Fufa, MD

Initial Patient Information Form

Name:___________________________________ **Referred by**:____

Age:___________ **Date Of Birth**:______________ **Family doctor, Address** (if you'd like a copy of the notes from

Today's Date:_____________________________ this visit sent): _______________________________________

____

Tell me about why you came to see me today…

I write with my: (circle) Right Left hand.

Body part affected: (circle) Right Left ; Thumb / Index / Middle / Ring / Small finger

Hand Wrist Arm Leg

How problem started: ____

____ When/Date? _____________________________________

My problem is (circle **all** that apply): pain numbness/tingling weakness catching/locking
stiffness swelling wound healing

Other: ____

Tell me about what you have already done for the problem…

Check all that apply

___ Take medication. Which:____

___ Seen another doctor. Name:____

___ Therapy

___ Have an injection. Date:________________ Effect:____

___ Have surgery. Type and dates:____

___ Other:____

Work activities, sports or hobbies that are limited by your current problem:____________________________________

Patient Signature:____ Date: ________________

Reviewed By:____ Date:________________

Tell me more about yourself…

Medical History: (circle **all** that apply)

High blood pressure   Heart disease   Diabetes

Hepatitis   Osteoporosis/Low bone density   Cancer

Alcohol or substance abuse

Other:____

Family History: Blood clots/Stroke   Cancer   Bone disorder   Other:__________________________

Past Surgeries:

____

____

Medications:____

____

Allergies:____

Current Job:____

Any limitations due to this problem:____

Smoker?:   Current   Previous   No   ;   If current,__________packs/day   ;   If quit, date:___________________

Please circle Y or N to indicate if you have problems with any of the following:

Y	N	Fever/Chills	Comment:	
Y	N	Unexplained weight loss	Comment:	
Y	N	Eyes (not including glasses)	Comment:	
Y	N	Ears, nose, throat, mouth	Comment:	
Y	N	Cardiovascular (heart)	Comment:	
Y	N	Respiratory/Lung/Breathing	Comment:	
Y	N	Gastrointenstinal System (stomach, bowels)	Comment:	
Y	N	Skin/Breast	Comment:	
Y	N	Neurologic condition	Comment:	
Y	N	Psychiatric condition	Comment:	
Y	N	Endocrine/gland condition	Comment:	
Y	N	Blood vessels/Lymphatics	Comment:	
Y	N	Allergy/Immunology	Comment:	
Y	N	Genitourinary system (bladder, kidneys)	Comment:	

Patient Signature:____ Date: ________________

Reviewed By:____ Date:________________