CUCCHETTI ORTHOPEDICS & SPORTS MEDICINE
BRAD A. CUCCHETTI, D.O.
2017

NAME: _____ DOB: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ SOCIAL SECURITY: _____

EMAIL: _____

EMERGENCY CONTACT: _____PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

CURRENT EMPLOYER: _____ PHONE: _____

What are you being seen for:

_____

_____

Describe how the injury occurred:

Date of onset problem: _____

Have you had X-rays? Yes / No If yes, where?

Have you had an MRI? Yes / No If yes, where?

Previous Surgeries: _____ Date:

_____ Date:

Hospitalizations: _____ Date:

_____ Date:

CURRENT SYMPTOMS: **Circle any that apply to the current problem**

Aching	**Throbbing**	**Popping**	**Spasmodic**	**Numbness**	**Giving Away**
Sharp	**Numbing**	**Grinding**	**Periodic**	**Soreness**	**Going Elsewhere**
Burning	**Shooting**	**Stiffness**	**Paralysis**	**Tingling**	**During Activity**
Dull	**Knife-like**	**Electrical**	**Tenderness**	**At Night**	**After Activity**

PERSONAL INFORMATION:

Marital Status: Married / Single / Divorced / Widowed/ Other: _____

Children? Yes / No **How many:** _____ **Do you live alone?** Yes / No

How often do you exercise? Daily / Weekly / Rarely / Never

Are you on a special diet? Yes / No **If so explain** _____

History of Substance Abuse (Drugs or Alcohol) Yes / No **Explain:** _____

Do you currently smoke? Yes / No **Previous Smoker?** Yes / No **Year Quit:** _____

Do you drink alcohol? Yes / No Daily / Weekly / Rarely / Socially / Never

MEDICAL HISTORY **Current and past medical problems (please circle all that apply)**

Blood Pressure: High / Low	**Blood Clot**	**Heart Problems**	**Bladder**	**Kidney**
Abnormal Bleeding	**Diabetes**	**Bowel Problems**	**Anemia**	**Stomach**
Shortness of Breath	**Asthma**	**Psychiatric**	**Pacemaker**	**AIDS/HIV**
Artificial Joints/Bones	**Eye/Ear/Nose**	**Low Back Pain**	**Epilepsy**	**Gout**
Abnormal Bleeding	**Polio**	**Bone Infections**	**Drug Abuse**	**Alcohol Abuse**
Radiation	**Cancer**	**Hepatitis**	**COPD**	**Depression**
High Cholesterol	**Stroke**	**Sleep Apnea**	**Anxiety**	**Fibromyalgia**

Other: _____

Medications: _____ **Dose:** _____

_____ _____

Allergies: **Reaction:**