The Brooklyn Hospital Center
Keeping Brooklyn healthy.

DATEOF INJURY: _____

DESCRIBE INJURY: _____

DATE OF DISABILITY ONSET: _____

CHIEF COMPLAINT:

Joint or area: _____

Please √ YES or NO:

•Deformity	☐ Yes	☐ No
•Pain	☐ Yes	☐ No
•Buckling	☐ Yes	☐ No
•Locking	☐ Yes	☐ No
•Stiffness	☐ Yes	☐ No
•Swelling	☐Yes	☐ No

Other: _____

IF BUCKLING:

a. Frequency: _____

b. Due to:

1. Sudden pain? _____
2. Sudden weakness? _____
3. Definite shift in joint? _____

c. Did the kneecap move? _____

d. Did you ever have a loose body in the knee? _____

e. Have you ever fallen? _____

IF PAIN:

a. Time of the day when worst? _____

b. Constant or intermittent? _____

c. Sharp_____ Dull _____ Droning _____

d. Other: _____

PREVIOUS TREATMENT TO DATE:

- Medications: _____
- Physiotherapy: _____
- Casts & Braces: _____
- Surgery: _____

PREVIOUS DIANOSTIC EXAMS TO DATE: (Please list dates)

- X-rays: _____
- Arthrograms: _____
- Arthroscopy: _____

The Brooklyn Hospital Center
Keeping Brooklyn healthy.

JOSEPH F. FETTO, M.D.

Chairman of Department of Orthopaedic Surgery
Director of Division of Adult Reconstruction
The Brooklyn Hospital Center

Phone: 718-250-7700
Fax: 718-250-8550
Email: jfetto@tbh.org

Clinical Associate Professor of Orthopedics
Department of Orthopaedic Surgery
Hospital for Joint Diseases

TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____ AGE:_____

SOCIAL SECURITY #:_____

HOME ADDRESS: _____

_____

HOME PHONE :(_____)_____BUSINESS PHONE: (_____)_____

CELL PHONE: (_____)_____

EMAIL ADDRESS:_____

BILLING ADDRESS:_____

_____

OCCUPATION: _____

EMPLOYERS NAME/ADDRESS: _____

WHOM WERE YOU REFERRED BY? _____

PRIMARY PHSICIAN'S NAME: _____

ADDRESS: _____

TELEPHONE: (_____)_____ FAX: (_____)_____

PRIMARY INSURANCE CARRIER: _____

POLICY #_____ TELEPHONE: (_____)_____

POLICY HOLDER/RELATIONSHIP/D.O.B: _____

SECONDARY INSRANCE CARRIER: _____

POLICY # _____ TELEPHONE: (_____)_____

POLICY HOLDER/RELATION/D.O.B: _____

WHOM SHALL WE NOTIFY IN THE EVENT OF AN EMERGENCY?

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

CONTACT TELEPHONE NUMBER: (_____)_____

PREVIOUS PHYSICIANS WHO HAVE TREATED YOU TO DATE:

1. _____
2. _____
3. _____

GOALS & TREATMENT:

_____

_____

_____

WHICH DAILY ACTIVITIES, THAT YOU **MUST** DO, DOES YOUR PROBLEM PREVENT?

_____

_____

_____

WHICH DAILY ACTIVITIES, THAT YOU **LIKE** TO DO, DOES YOUR PROBLEM PREVENT?

_____

_____

_____

BONE & JOINT

(Please circle Yes or No)

YES NO Have you ever been treated for calcium deposits? **If so, please give location**

_____

YES NO Have you ever had any injury to the neck involving nerves, vertebrae or vertebral disc?

YES NO Have you ever had a shoulder dislocation, separation or other injury that incapacitated you for a week or Longer?

YES NO Have you ever experienced any injury to your throwing arm, elbow or shoulder?

YES NO Have you ever had any injury to your back?

If answered **YES** to above, did you seek the advice or care of a medical **doctor?** _____ **Whom:** _____

YES NO Have you experienced pain to your back?

If answered YES to above, please indicate the frequency with which you experienced this pain.

(Please circle below)

Very seldom, Occasionally, Frequently or Only after vigorous exercising or heavy lifting

YES NO Have you ever been told you injured the ligaments of either knee joint?

YES NO Have you ever been told you injured the cartilage of either knee joint?

YES NO Have you ever been advised to have knee surgery to correct a condition?

If YES, has the surgery been completed? _____

YES NO Have you ever experienced a severe sprain of either ankle?

YES NO Do you have a pin, screw or plate somewhere in your body as a result of bone or joint surgery?

If YES, please indicate the anatomical site and date the surgery was completed?

_____

YES NO Have you ever had a bone graft or spinal fusion?

If YES, please indicate the site: _____

YES NO Have you ever had a fracture during the past two years?

IF YES, please indicate the site: _____

GENERAL

(Please circle YES or No)

YES NO Have you ever had any operation during the past two years?

If YES, please indicate the site &date of surgery: _____

YES NO Have you had any additional illnesses, injuries or operations? (Other than childhood disease) ?

If YES, please indicate specific illness or operation _____

_____

MEDICAL HISTORY

(Please circle Yes or No)

YES NO Have you ever experienced an epileptic seizure or been informed that you might have epilepsy?

YES NO Have you had hepatitis?

YES NO Have you ever been treated for diabetes?

If so, do you take medication? _____ **If so, which medication?** _____

YES NO Do you have an allergies?

If so, do you take any medications? _____

YES NO Have you ever been "Knocked Out" or experienced a concussion?

If YES, has it happened more than once? _____

If so, did the attending physician keep you in the hospital overnight? _____

YES NO Have you ever been advised by a medical doctor not to participate in the sport in which you are now contemplating participation?

YES NO Have you ever had a tetanus shot?

If so, when? _____

YES NO Do you take any medication on a regular basis?

If YES, please list medication & reason for use: _____

_____

All of the above questions have been answered completely and truthfully to the best of my knowledge.

_____

Patient Signature (or Legal Guardian)

The Brooklyn Hospital Center

Keeping Brooklyn healthy.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____ acknowledge that I have been provided with a copy of The Brooklyn Hospital Center's privacy notice.

Date: _____, 20____

Medical Record # _____

_____

Patient/Patient Representative Signature

-Unable to sign

-Refuses to sign

THIS FORM IS TO BE KEPT WITH THE PATIENT'S MEDICAL RECORDS.