

Donald Dolce, MD
Fort Worth Orthopedics

Please answer all questions - circle answers where indicated

Name: _____ Age: _____ DOB: _____
Race: _____ ☐ Ethnicity ☐ Hispanic/ Latino ☐ Non-Hispanic or latino ☐ Decline to specify
Primary care physician (PCP): _____
Pharmacy Name: _____ Phone#: _____

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

List any allergies: _____

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

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

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: _____

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

If yes, what facility was imaging done at? _____

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

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