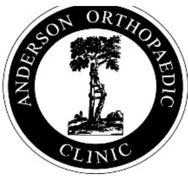

Anderson Orthopaedic Clinic

Oliver Schipper, MD

New Patient History Form Date:________________

Name:___________________ DOB:_____________ Sex:_________________

Height: _______ Weight:_________ Occupation:________________ Employer: _________________

Family/Primary Doctor's name and address: ____

Preferred Pharmacy: ____

Who referred you to Dr. Schipper?____

Reason for today's visit? Right Ankle / Left Ankle / Right Foot / Left Foot

____

When did the problem first start or when did the injury occur?____

In your own words, how did this injury occur or this condition start?____

____

Severity of pain on a scale from 1-10: ________

What treatments have you tried thus far?(i.e. Orthotics , PT, Injection, Pain medication)

____

Other doctors seen for this injury/condition?____

Circle all that apply:

Is your pain: Improving Worsening Unchanged Constant Intermittent **Timing:** Morning Night Activity-related

Quality: Sharp Dull Throbbing Burning

What improves your pain? Rest Ice Elevation Anti-Inflammatories Brace Orthotics Other: ______________

What makes it worse? Standing Walking Running Exercise Twisting Other: ____________________________

What associated symptoms do you have? Swelling Bruising Numbness Tingling Other:_______________________

Does pain radiate? If so, where? ____

Social History:

Do you use tobacco? ☐Y ☐N If yes, packs per day? __ No, were you ever an active smoker? ☐Y ☐ N

Alcohol use? ☐Y ☐N If yes, how often? ☐Daily ☐ Other _____/week

Family history: Have any direct relatives had any of the following disorders? If so, who?

☐Diabetes ___________________________☐ High Blood Pressure ___________________________

☐ Rheumatoid Arthritis ______________________☐Blood clots (DVT or PE)_______________ __________

☐Other_________________

Reviewed by:_____________

Anderson Orthopaedic Clinic

Oliver Schipper, MD

New Patient History Form Date:________________

Past medical history (circle all that apply):

1. Diabetes Mellitus
   a. Most recent Hemoglobin A1C:___________
2. Hypertension
3. Blood clots (DVT or PE)
   a. How long ago?____________________
4. Coronary artery disease
5. Peripheral vascular disease
6. Foot/ankle ulcers
7. Asthma
8. COPD
9. HIV
10. Hepatitis A/B/C
11. End stage renal failure
12. Cancer (Type:________________)

Medication allergies (circle all that apply):

1. No known allergies
2. Penicillin
3. Sulfa
4. Aspirin
5. Anti-inflammatories
6. Morphine
7. Codeine
8. Percocet
9. Vicodin
10. Iodine
11. Adhesive tape
12. Other______________________________

Do you take any of the following: (please circle)

Aspirin Plavix Xeralto Coumadin Eliquis

Please list any previous surgeries:

____
____
____
____

Please list all other medications:

____
____
____
____

Review of Systems:

In the last 3 months, have you had any of these symptoms? If no, mark None.

				NONE
1)	**GI**	☐ Nausea	☐Vomiting	
2)	**CON**	☐Weight Loss	☐ Fever or Chills	☐
3)	**EYE**	☐Blurred Vision	☐Vision Loss	☐
4)	**CV**	☐Chest Pain	☐ Palpitations	☐
5)	**RESP**	☐Chronic Cough	☐ Shortness of Breath	☐
6)	**SK**	☐ Frequent Rashes	☐ Skin Lesions	☐
7)	**NEU**	☐ Dizziness	☐ Numbness/Tingling	☐
8)	**PSY**	☐Depression	☐ Drug/Alcohol Addiction	☐
9)	**HEM**	☐Easy Bleeding	☐ Easy Bruising	☐
10)	**ENDO**	☐Sensitive to cold	☐ Sensitive to heat	☐

Reviewed by:______________