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:_____

Who referred you to Dr. Schipper?_____

Reason for today's visit?_____

_____

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?(orthotics Injection pain medication)

_____

_____

Other doctors seen for this injury/condition?_____

_____

Circle all that apply:

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

Quality: Sharp Dull Throbbing Stabbing Burning

What improves your pain? Rest Ice Elevation Anti-Inflammatories Orthotics Other: _ _____

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

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

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 <u>direct</u> relatives had any of the following disorders? If so, who?

☐ Diabetes _____ ☐ High Blood Pressure _____

☐ Rheumatoid Arthritis _____ ☐ Blood clots (DVT or PE)_____ _____

☐ Other_____

Reviewed by:_____

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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**	☐ Easy Bleeding	☐ Heat/cold intolerance	☐

Reviewed by:_____