



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? _____

About how often and how far would you say you walk in a week? (There are about 2,000 steps in a mile, 144 steps in a football field, 17.6 football fields in a mile) _____

What type of shoes do you primarily wear? _____

Do you have a desk job? YES NO What is your favorite activity? _____

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

Reviewed by: _____



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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) _____

Past medical history (circle all that apply):

1. Diabetes Mellitus
 - a. Most recent Hemoglobin A1C: _____
2. Hypertension
3. Blood clots (DVT or PE): when? _____
4. Coronary artery disease
5. Stroke
6. Atrial Fibrillation
7. Peripheral vascular disease
8. Foot/ankle ulcers
9. Asthma
10. COPD
11. HIV
12. Hepatitis A/B/C
13. End stage renal failure
14. Problems with anesthesia _____
15. Cancer (Type: _____)
16. Other: _____

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 _____

Have you ever had an adverse reaction to anesthesia?

YES NO

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

Aspirin Plavix Xeralto Coumadin/Warfarin 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.

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

Reviewed by: _____