Anderson Orthopaedic Clinic

New Patient History Form | Oliver N. Schipper, MD

Name: ______________________________ DOB: __________ Date of visit: _________ Sex: ______

Occupation: ______________________ Employer: ____________________

Primary Doctor's **name, phone**, and address: ____

Who referred you to Dr. Schipper and Martelle Blaine PA-C? ____________________________________

Reason for today's visit **(Circle all that apply)**: Right Ankle / Left Ankle / Right Foot / Left Foot

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

If injury, what was mechanism/how did it occur? ____

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

____

Other doctors seen for this injury/condition? ____

What type of shoes do you primarily wear? _______________ 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 Anti-Inflammatory Brace Orthotics Other: ______________________

What makes it worse? Weight bearing Walking Running Other: ______________________________

What associated symptoms do you have? Swelling Radiating pain Other: ___________________________

Severity of pain on average from 0(no pain at all) to 10(severe pain): _______

Please list all medications, vitamins, supplements & dosage: NONE: ☐

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____

____

MD SIG _____

Name: ________________________________ *DOB:* ____________

Preferred Pharmacy and phone number: ______________________________

Please list any allergies to medications & reaction: NONE: ☐

____

Other allergies (metal, iodine, shellfish etc.): ______________________________

Your past medical history (circle all that apply):

1. Diabetes Mellitus
   a. Most recent Hemoglobin A1C: __________
2. Hypertension
3. Deep Vein Thrombosis (DVT): when? __________
4. Pulmonary Embolism (PE): when? __________
5. Coronary artery disease
6. Stroke
7. Atrial Fibrillation
8. Foot/ankle ulcers
9. Asthma
10. COPD
11. Sleep apnea (CPAP: yes/no)
12. HIV
13. Hepatitis A/B/C
14. Cancer (Type:____________________)
15. Other: ______________________________
16. NONE: ☐

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

Aspirin Plavix Xarelto
Coumadin/Warfarin/Eliquis

Have you ever had an adverse reaction to anesthesia?

YES NO

Please list any past surgical or medical procedures below: ☐ NONE

____

____

____

Do you now or have you ever smoked or use tobacco?

☐Yes ☐No ☐ Never If currently: ____ packs per day for ___ years Quit date: ________

Do you drink alcohol?

☐Yes ☐No ☐ Never If yes: How often? ☐Daily ☐Other ______________ /week

OFFICE USE ONLY

Height: __________ **Weight:** ____________ **Temp:** ______________

MD SIG ______