Megan Wolf, MD New Patient Form

Name: _____ Date: _____
Age: _____ DOB: _____
Marital Status: _____ Employer: _____
People in Household (include self)_____ Current Occupation/Job: _____
Activities, Hobbies: _____
_____
Referring Doctor: _____ Primary Care Doctor: _____

Please describe why you are here today: (right/left/both)_____
_____
Date Problem Began: _____ Reported to employer? Yes No
Result of Injury? Yes No Involves a Legal Case? Yes No
Happen at work? Yes No Date: _____
If a work injury, have you worked since? Yes No Last day worked? _____

Have you EVER had any of the following treatments/tests for <u>THIS</u> problem (check any/all that apply):

____Orthotics
____Cast Immobilization
____Bracing (e.g., boot, stirrup, lace-up, splint)
____Injection
____Physical Therapy
____ Surgery: 1. Type: _____Date: _____Surgeon:_____ Helped?____
2. Type: _____Date: _____Surgeon:_____ Helped?____

____X-rays
____MRI
____CT
____EMG/Nerve Study
____Bone Scan

Pain Location: _____
<u>Level, currently</u>: (no pain) 0—1—2—3—4—5—6—7—8—9—10 (worst pain imaginable)
<u>Improves with</u>: _____
<u>Timing:</u> during activity after activity never sometimes always standing sitting nighttime unpredictable
<u>Description:</u> sharp dull burning constant intermittent infrequent gradual sudden improving worsening

Current Work status: full duty light duty unemployed retired permanently disabled
Weight bearing status on affected side: non touchdown partial full
Immobilization: none post-op shoe sleeve/stirrup boot splint toe protector cast AFO custom brace
Assistive device: none crutches walker wheelchair cane other
Driving status: yes no

Do you have Instability? Yes No
You are currently able to: stand walk jog run jump climb cycle play sports wear shoes go outside
You are here today with: Alone Spouse Parent Child Sibling Friend Relative Interpreter Case Manager
Normally live with: Alone Spouse Parent Child Sibling Friend Relative
What is your housing status? House Apartment Rehab Center Nursing Home Assisted Living
Is your typical shoe wear? Sneakers Sandals Heels Diabetic Wear SAS Loafers Dress Other

<u>Do You</u>: Smoke (Now or Ever)? Yes__ No __ If yes, how many PPD? _____
Consume alcohol? Yes__ No __ If yes, how much per week? _____
Think you might be pregnant? Yes __ No__
Use IV drugs (Now or Ever)? Yes __ No __
Exercise regularly? Yes __ No __
Have any problems after surgery? Yes __ No __
Use nicotine? Yes __ No __
Have diabetes? Yes __ No__ If yes, last A1C: _____

Your Height: _____ Weight: _____ Shoe Size:_____

PLEASE circle AND check, respectively, your past medical history:

Diabetes	Yes	No	Fibromyalgia	Yes	No
Rheumatoid Arthritis	Yes	No	Anxiety	Yes	No
Osteoarthritis	Yes	No	Reflux	Yes	No
Cancer	Yes	No	Heart Attack	Yes	No
Blood Clots	Yes	No	Coronary Artery Disease	Yes	No
Ulceration (foot, ankle, or leg)	Yes	No	Peripheral Vascular Disease	Yes	No
Open Wounds	Yes	No	Arrhythmia (irregular heartbeat)	Yes	No
Osteomyelitis	Yes	No	High Cholesterol	Yes	No
Infection	Yes	No	High Blood Pressure	Yes	No
History of MRSA Infection	Yes	No	Psychiatric Illness	Yes	No
Depression	Yes	No	Pneumonia or Aspiration	Yes	No
Gout	Yes	No	Seizures	Yes	No
Ulcers (gastric, duodenal)	Yes	No	Asthma	Yes	No
Hepatitis	Yes	No	Hypo or Hyperthyroidism	Yes	No
Kidney Disorders	Yes	No	Lung Disease	Yes	No
Bleeding Problems	Yes	No	Sexually Transmitted Disease	Yes	No
Pulmonary Embolus	Yes	No	Back Problems	Yes	No
Stroke	Yes	No	Sleep Apnea	Yes	No
RSD (or CRPS)	Yes	No	HIV	Yes	No
Family History of Blood Clots?	Yes	No			
Which Family Member?	_____				

List Other Medical Problems You Have Ever Had: _____
_____

List Any Surgery You Have Ever Had: _____
_____

Please Circle *Any* Applying Recently: fevers chills weight loss night pain excessive sweating itchiness skin sensitive to light touch shiny skin tick/insect bites serious personal problems lumps/bumps blurred vision shortness of breath palpations urinary problem difficulty walking easy bruising abdominal discomfort cough loss of appetite body aches back pain leg pain numbness/tingling joint swelling constipation drowsiness locking of joint nail deformity redness nausea vomiting wound drainage rashes

Please List All Medications *AND DOSAGES* That You Currently Take:_____
_____
_____
_____

Please List All Allergies (+ Reaction) To Medications or Medical Substances: _____
_____

Dr. Megan Wolf_____ Patient Signature_____