TEXAS FOOT & ANKLE ORTHOPAEDICS

WILLIAM S. CRAWFORD, MD

NEW PATIENT INTAKE FORM

Patient Name: _____ DOB: _____

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. Answer each question in as much detail as possible. Write additional information on the back if necessary. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care.

Would you be interested in taking part in a research study? YES / NO

Who referred you to Dr. Crawford, or how did you hear about us? _____

What brought you to see Dr. Crawford today? _____

When did your symptoms **FIRST** begin? (Date if known) _____

Have you seen another doctor for this issue? YES / NO If yes, who, when, and what treatment have you undergone?

_____

_____

Please explain in your own words how the injury happened, and what makes your symptoms better or worse:

_____

_____

_____

HEIGHT: _____ **WEIGHT:** _____

ALLERGIES: Check anything listed below to which you are allergic.

(_) No known allergies
(_) Penicillin
(_) Tetracycline
(_) Sulfa
(_) Morphine
(_) Erythromycin
(_) Codeine
(_) Iodine/Betadine/Shellfish
(_) Radiographic Dyes
(_) Latex
(_) Adhesive Tape
(_) Other (Specify): _____

PHARMACY NAME & NUMBER: _____

PREVIOUS MEDICATIONS:

Please circle any of the following medications which you have taken in the **PAST**:

Advil (Ibuprofen)	Naprosyn/Aleve (Naproxen)	Ultram	Mobic (Meloxicam)
Voltaren	Indocin (Indomethacin)	Aspirin	Lodine (Etodolac)
Toradol (Ketorolac)	Arthrotec (Diclofenac)	Celebrex (Celecoxib)	

Please list any side effects you experienced while taking any of the above (please specify)

Nausea Diarrhea Gastric Ulcers Gastric Bleeding Upset Stomach Vomiting

Other: _____

Are you currently taking any of the following blood-thinning medications on a regular basis?

Aspirin Coumadin Heparin Plavix Xarelto Pradaxa Lovenox

Other: _____

What medications are you **CURRENTLY** taking? (Please include all prescription and over the counter medications)? **You may use the back of the page, if needed, to list additional medications.**

Medication Dose Frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you involved in a pain contract? YES / NO If so, with whom? _____

PAST SURGICAL HISTORY: Please indicate the year of the surgery

(_) No previous surgeries
(_) Appendectomy _____
(_) Cataract Extraction _____
(_) Hysterectomy _____
(_) Lumbar laminectomy _____
(_) Mastectomy _____

(_) Heart Surgery (CABG) _____ (_) Tonsillectomy _____
(_) Cardiac Stent _____ (_) Prostate Surgery _____
(_) Gall Bladder _____ (_) Other (specify) _____
(_) Hernia Repair _____ _____
(_) Gastric Bypass _____ _____

PAST MEDICAL HISTORY: Check any medical problems that you have had. Indicate if the problem is current (even if it is being treated) or resolved

(_) I have no known medical problems
(_) Hypertension (high blood pressure)
(_) Coronary artery disease
(_) Peripheral vascular disease
(_) Adult onset diabetes
(_) Childhood onset diabetes
(_) Past heart attack
(_) Asthma
(_) Ulcers
(_) Hepatitis A / B / C
(_) Cancer
(_) Blood Clot (DVT / PE)
(_) Blood Transfusion (year) _____
(_) HIV/AIDS
(_) Tuberculosis
(_) Liver disease
(_) Seizure disorder
(_) Thyroid disease
(_) Emphysema
(_) COPD/Lung problems
(_) Immune Disorder (specify): _____
(_) Overweight
(_) Osteomyelitis
(_) Arthritis (where?): _____
(_) Fibromyalgia
(_) Other (specify):_____
_____
_____

FAMILY HISTORY: Has anyone in your immediate family (mother, father, sister, brother, children) had any of the following? Please specify whom.

(_) None	(_) Hypertension	(_) Hypothyroidism	(_) Tuberculosis
(_) Cancer	(_) Heart Disease	(_) Colitis	(_) Seizure disorder
(_) Leukemia	(_) Rheumatic Fever	(_) Bleeding tendency	(_) Alcoholism
(_) Stroke	(_) Diabetes	(_) Asthma	(_) Other _____

SOCIAL HISTORY:

Occupation (if retired, list previous) _____

ALCOHOL: How much alcohol do you consume?

(_) I'm a non-drinker	(_) I Drink weekends only	(_) Average 3-5 drinks/day
(_) I'm a recovering alcoholic	(_) Average 1-2 drinks/day	(_) More than 6 drinks/day
(_) I drink only occasionally	(_) Average 2-3 drinks/day	

NICOTINE: Check all that apply

(_) I do not use nicotine
(_) I am a former smoker: _____packs per day for _____ years. I stopped in (year) _____
(_) I am a current smoker: _____packs per day for _____ years
(_) I use other nicotine (dip / chew / E cigarette / vapor / gum / patch) _____

DRUGS: Do you or have you ever used illicit drugs? YES / NO

(_) Recreational	(_) Marijuana	(_) Methamphetamines
(_) Cocaine	(_) Heroin	(_) Other (specify) _____

REVIEW OF SYSTEMS: Have you recently experienced any of the following?

General:

Weight gain	YES / NO
Weight loss	YES / NO
Fever	YES / NO
Chills	YES / NO
Night Sweats	YES / NO

Skin:

Change in moles	YES / NO
Rash	YES / NO

Eyes:

Loss of vision	YES / NO
Double/Blurry vision	YES / NO

Ear/Nose/Throat:

Hearing loss	YES / NO
Nose bleeds	YES / NO

Vascular:

Swelling in legs	YES / NO
Blood clots	YES / NO

Musculoskeletal:

Muscle weakness	YES / NO
Stiffness	YES / NO
Joint pain	YES / NO

Gastrointestinal:

Nausea	YES / NO
Vomiting	YES / NO
Change in bowel habits	YES / NO
Heartburn	YES / NO

Respiratory:

Shortness of breath	YES / NO
Coughing/Wheezing	YES / NO

Cardiovascular:

Chest pain	YES / NO
Palpitations	YES / NO
Fainting	YES / NO

Genitourinary:

Frequent urination	YES / NO
Difficulty with urination	YES / NO
Blood in urine	YES / NO

Psychiatric

Anxiety	YES / NO
Depression	YES / NO
Confusion	YES / NO
Memory loss	YES / NO

Neurologic:

Dizziness	YES / NO
Burning/tingling	YES / NO

The doctor will discuss your current problem with you in detail. The following questions are intended to give an overview of how it is affecting you now. Please select the ***best*** choice for each item below.

Do you have pain?

(_) None
(_) Mild, occasional
(_) Moderate, daily
(_) Severe, almost always present

What is your activity level?

(_) No limitations, no support
(_) No limitations of daily activities, limitation of recreational activities, no support
(_) Limited daily and recreational activities, cane
(_) Severe limitation of daily and recreational activities, walker, crutches, wheelchair, brace

Footwear requirements

(_) Fashionable, conventional shoes, no insert(s) required
(_) Comfort footwear and/or shoe insert
(_) Modified shoes or brace

Maximum walking distance

(_) Greater than 6 blocks
(_) 4-6 Blocks
(_) 1-3 Blocks
(_) Less than 1 block

Walking surfaces

(_) No difficulty on any surface
(_) Some difficulty on uneven terrain, stairs, inclines, ladders
(_) Severe difficulty on uneven terrain, stairs, inclines, ladders

Everything I have answered is true and correct to the best of my knowledge.

Patient signature: _____ **Date**: _____

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.
IT WILL BECOME PART OF YOUR PERMANENT MEDICAL RECORD WITH **TEXAS FOOT & ANKLE ORTHOPAEDICS** AND WILL PLAY AN IMPORTANT PART IN UNDERSTANDING YOUR CURRENT SITUATION AND FOLLOWING YOU IN THE FUTURE.