The Orthopedic Center of St. Louis
John O. Krause, M.D.
Orthopedic Surgery; Surgery of the Foot & Ankle

NEW PATIENT INFORMATION

Name: ____________________ Age ____________
Referring Doctor: ____________________ Date of Birth: _____ / _____ / _____
How did you hear about Dr. Krause? ____________________ Phone # ____________
Primary Care Physician:__________ Address: ____________________Phone #__________

Chief Complaint: ________________________________
Date of Accident/Onset: ______ / ______ / ______ Which side is your problem on? ❑ Right ❑ Left
Please describe the recent events that brought on this orthopaedic problem: ____________________
____
How long has it been a problem? ________________________________
How often do you have pain? ________________________________
What makes it worse? ____________________ What makes it better? ____________________
Have you had prior treatment for this injury? ❑ Yes ❑ No What Treatment? When?____________________
____________________By Whom?____________________

Occupation__________ Employer __________ Hours__________
Do you smoke? ❑ Yes ❑ No Cigarettes / Cigars / Other __________ Quit? ______ Yr__________
How many packs per day? __________ How many total years have you smoked? __________
Do you use chew tobacco? ❑ Yes ❑ No Do you consume alcohol? ❑ Yes ❑ No How much/often? __________
List any activities that you participate in on a regular basis outside of work (sports, gardening, weight lifting, musical instruments, etc.) ____________________
Are you here for a work-related injury? ❑ Yes ❑ No If yes, please complete page 3
Do you have an attorney regarding this injury? ❑ Yes ❑ No If yes, who?____________________
Do you regularly attend religious services? ❑ Yes ❑ No
How important is religion/spiritual issues in your life? ❑ Very ❑ Moderately ❑ Somewhat ❑ Not important

HEALTH HISTORY

Height__________ Weight__________ Shoe Size__________

Question	Yes	No	Question	Yes	No
Do you have diabetes?	❑ Yes	❑ No	Do you have fibromyalgia?	❑ Yes	❑ No
Do you have rheumatoid arthritis?	❑ Yes	❑ No	Do you have lupus?	❑ Yes	❑ No
Do you have a thyroid problem?	❑ Yes	❑ No	Do you have gout?	❑ Yes	❑ No
Do you have any heart problems?	❑ Yes	❑ No	Do you have any lung problems?	❑ Yes	❑ No
Have you ever had a heart attack?	❑ Yes	❑ No	Do you have stomach ulcers?	❑ Yes	❑ No
Do you have high blood pressure?	❑ Yes	❑ No	Do you have or have you had hepatitis?	❑ Yes	❑ No
Do you have depression?	❑ Yes	❑ No	Do you have any other mental illness?	❑ Yes	❑ No
Do you have any bleeding disorders?	❑ Yes	❑ No	Do you have any kidney trouble?	❑ Yes	❑ No
Do you have seizures?	❑ Yes	❑ No	Do you have cancer?	❑ Yes	❑ No
Have you ever had a stroke?	❑ Yes	❑ No	Do you have anemia?	❑ Yes	❑ No
If you are a woman, are you pregnant?	❑ Yes	❑ No	Have you ever had a blood transfusion?	❑ Yes	❑ No
Have you ever had a blood clot in your legs or lungs?	❑ Yes	❑ No	Do you have HIV/AIDs?	❑ Yes	❑ No

Explain all yes answers and list any other medical problems: ____________________
____

PAST SURGICAL HISTORY: (List all surgeries you have had)

TYPE OF SURGERY	DATE (or approx. date)	WHERE	NAME OF SURGEON
____________________	_____ / _____ / _____	____________________	____________________
____________________	_____ / _____ / _____	____________________	____________________
____________________	_____ / _____ / _____	____________________	____________________
____________________	_____ / _____ / _____	____________________	____________________

MEDICATIONS: (List all medications you are currently taking, including vitamins, OTC meds, herbal medications)

MEDICATION	STRENGTH	HOW OFTEN

ALLERGIES:

Are you allergic to Latex? ❑ Yes ❑ No

Have you ever had an allergic reaction to a medication? ❑ Yes ❑ No If yes, please list:	
MEDICATION	REACTION

Have you ever had a bad reaction to aspirin or a non-steroidal anti-inflammatory type medication?(i.e. Motrin, Ibuprofen)
❑ Yes ❑ No If yes, what was the name of the medication and what happened? ____________________
____

FAMILY MEDICAL HISTORY:

Do any of your relatives (mother, father, brothers, sisters, aunts, uncles, grandparents) have any of the following medical problems?

Diabetes	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Rheumatoid arthritis	❑ Yes	❑ No	Bleeding Disorders	❑ Yes	❑ No
Lupus/Gout	❑ Yes	❑ No	Cancer	❑ Yes	❑ No
Heart problems	❑ Yes	❑ No	Lung problems	❑ Yes	❑ No
Anesthetic Reactions	❑ Yes	❑ No	Any other medical problems	❑ Yes	❑ No

Please explain all yes answers: ____

<u>Patient Expectations</u>

Patient Name: ______________________________________ Age: __________

Condition being treated: ____

Please check the box the most appropriately describes your current expectations for treatment.

- ❑ Definitely non-surgical
- ❑ Probably non-surgical
- ❑Not sure
- ❑ Either surgical or non-surgical
- ❑ Probably surgical
- ❑Definitely surgical

Please check off which factors most influence your decision to seek treatment. (Check all that apply)

- ❑ Pain the limits daily activities/work
- ❑ Pain that limits sporting activities
- ❑ Pain that limits shoewear
- ❑ I am unhappy with the appearance
- ❑ Concerns about long term damage to the bones/joint/ligaments
- ❑ Friends/family recommended I seek treatment
- ❑ Directed by workman's comp or an attorney

Review of Systems

(Circle all that apply)

General
Normal
Weight change
Fever / Chills
Fatigue / Malaise
Strength / Weakness
Overall status:________

HEENT
Normal
Headache
Vision: blurred,
Sensitivity to light (photophobia)
Ringing in ears (tinnitus)
Nasal discharge
Bloody nose (epistaxis)
Sore throat / Hoarseness

Cardiopulmonary
Normal
Chest pain, palpitations
Short of breath:
- exertional,
- laying down (orthopnea)
- wake up in middle of night (PND)

Cough, sputum
Wheezing
Dizzy when standing up (orthostasis)
Passing out (syncope)
Leg/calf pain with exercise/walking (claudication)

Hemo-Onc
Normal
Pallor
Bruising / Bleeding

Genito-Urinary
Normal
Blood in urine (hematuria)
Flank pain
Stones / Gravel

Gastro-Intestinal
Normal
Nausea / Vomiting
Heartburn (GERD)
Regurgitation
Vomit blood (hematemesis)
Coffee ground vomit
Abdominal pain
Constipation / Diarrhea
Jaundice

Neurological
Normal
Loss of consciousness
Seizures
Numbness / Tingling

Musculoskeletal
Normal
Weakness
Swelling / Pain
Stiffness (in am)
Back pain
Joint pain

OB/GYN
Normal
Menstrual cycle:
- Normal
- No period (amenorrhea)
- Excessive
- Bleeding
- Spotting
- Menopausal

Breast: pain, masses, lesions, ulceration's

Endocrine
Normal
Neck mass / pain (goiter)
Lethargy / Fatigue
Breasts in males (gynecomastia)
Obesity (truncal, facial)
Flushing

Psychiatric
Normal
Personality disorder:
____
Depression
Anxiety
Schizophrenia
Bipolar
Suicide ideation
Homicide ideation
Drug abuse

Skin
Normal
Eczema
Psoriasis
Atopic dermatitis
Keloids
Rashes / Sores
Pain / Itching

COMPLETE THIS SECTION ONLY IF YOU ARE HERE FOR A WORK-RELATED PROBLEM

Your answers to these questions are very important. Please take the time to be as accurate and as specific as possible.

WORK HISTORY:

What is your current occupation? ____

What company do you currently work for? ____

What was your occupation when you developed the problem that you are being seen for? ______________________

What company were you working for when you developed this problem? ______________________

When did you first start working for this company? ____

If you are no longer working for this company, when did you last work for this company? ______________________

How many hours a day do you (or did you) work? ____

How many hours a week do you (or did you) work? ____

Describe your job in detail (the job you were working when you developed your problem):

- What do you do with your hands and arms at work? ____
  ____
- How often do you do these activities? ____
- How much do you lift? ____
- How often? ____
- If you do data entry, how many hours a day? ____
- Is it continuous or intermittent? ____
- If you do something repetitive, how many times an hour do you do it? ______________________

Additional Comments: ____

____

____

Do you have a second job? ❑ Yes ❑ No If yes, please describe what you do and list how many hours per day and week you work there: ____

____

PAST WORK HISTORY:

Please list the type of work you did before you worked for the company you were working for when you developed this problem:

- Where did you work? ____
- How long did you work there? (from when to when) ____
- What did you do? ____

Additional Comments: ____

Are you currently working your regular job? ❑ Yes ❑ No If so, are you on light duty? ❑ Yes ❑ No

Additional Comments: ____

If you are on light duty, what are your work restrictions? ____

____

Signature: ____ Date: ______ / ______ / ______