THE STEADMAN CLINIC
STEADMAN PHILIPPON RESEARCH INSTITUTE

Steadman Clinic Foot/Ankle Submission
Dr. Clanton & Dr. Haytmanek

The patient submission form is used to determine patient candidacy for an office visit. We use this to assist with scheduling visit times. If you are an appropriate patient for our practice, you will be contacted by the scheduling department for an available appointment. Otherwise images/records will be returned.

For administrative and processing we require 25 dollars for these reviews

Name:_____Billing Zip:_____
Credit Card #:_____Exp:_____Security Code:_____

You WILL NOT be contacted by Physician or his office staff to discuss cases
We do not discuss the injury or treatment plan over the phone
Only at your potential appointment will we discuss treatment options

GATHER ALL *RELEVANT* & *PREFERABLY RECENT* (within 1 year)
IMAGES *SHOULD BE ON DISKS* (X-RAY, MRI, CT-SCAN)

INCULDE *ALL REPORTS* OF IMAGES & PROCEDURES

COMPLETE THE SUBMISSION AND HISTORY

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WE RECOMMEND PATIENTS GATHER & MAIL ALL MATERIALS TO AVOID DELAY/MISS-SHIPPING FROM IMAGE CENTERS/CLINICS TRACKING NUMBERS IF YOU WISH TO KNOW ARRIVAL STATUS

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Once ALL images/records are received, we do our best to review as quickly as possible. Due to our clinical and surgical schedule, this process may take **SEVERAL WEEKS**, as we review images only on certain days.

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Once ALL images/records are received, we do our best to review as quickly as possible. Due to our clinical and surgical schedule, this process may take **Several Weeks**, as we review images only on certain days.
Reviews without Complete History, Review Sheet and current Images will not be reviewed

Please Provide the Following to Assist Us with Your Clinical Review:

Name:_____ ☐ **Male** ☐ **Female DOB**:_____**Age**:_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Contact Number:_____**How did you find us?** _____

Primary Insurance:_____**Secondary Insurance:**_____

Please Clearly Indicate Area of Review:
☐ **Left** ☐ **Right** ☐ **Foot** ☐ **Ankle** **Date/Length of Injury**:_____

Describe Original Injury:_____

_____

Please Describe Current Symptoms:_____

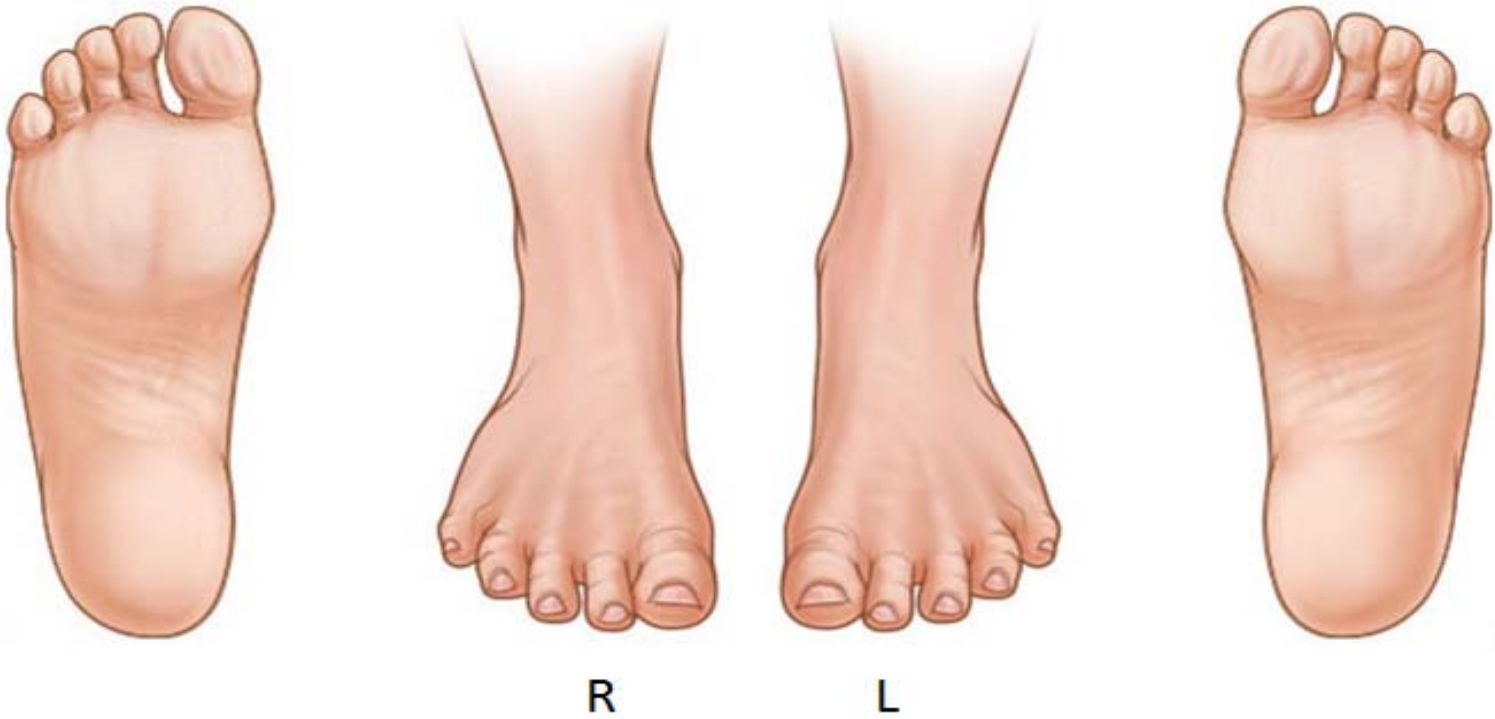
_____

Diagnosis/Plan from Other Physician:_____

_____

_____

On the Pictures below please use an X to indicated areas of pain



Thank you for contacting *The Steadman Clinic* to review your information

Office Only (Notes) _____ Review Received: _____ Images Received: _____ Images Reviewed: _____ Scheduled:

☐ Referral: _____ ☐ Images Needed:_____ ☐ Schedule NP or FR

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The Steadman Clinic Patient History Form

Name:_____ **Nickname:**_____ **Today's Date:**_____

Date of Birth:_____ **Age:**_____ **Height:**_____ **Weight:**_____

History of Injury

Is this related to a: ☐ Work Injury? ☐ Sport Accident? Or ☐ Motor Vehicle Accident? If So, What State?____

Which Body Part is Injured?_____ ☐ Right / ☐ Left **Hand Dominance:** ☐ Right / ☐ Left

Please list the Injury/Accident Date:_____ **If Chronic list how long:**_____

Please describe in your own words: (How the Initial Injury Occurred AND how it Limits Your Activity)

_____

_____

_____

Please Rate Your Pain on a Scale of 1 to 10: (10 being the most painful)

Rest: 0 1 2 3 4 5 6 7 8 9 10 **At Its Worst:** 0 1 2 3 4 5 6 7 8 9 10

Is the Pain: ☐ Constant or ☐ Occasional **Has it Been:** ☐ Worsening ☐ Stable ☐ Improving

Describe the Pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Sensitive to Touch

Do you have Pain at Night? ☐ Yes / ☐ No **Does the Pain Keep or Wake you from Sleep?** ☐ Yes / ☐ No (☐ Keep ☐ Wake)

What Symptoms are You Experiencing?

☐ Locking ☐ Catching ☐ Giving Way/Instability ☐ Popping ☐ Grinding ☐ Bruising ☐ Numbness ☐ Tingling
☐ Pain ☐ Weakness ☐ Swelling Other (Please describe):_____

What, If Anything, Makes Your Symptoms Better?

☐ Rest ☐ Activity ☐ Cold Therapy ☐ Heat Therapy ☐ Medication ☐ Other (Please describe):_____

What, If Anything, Makes Your Symptoms Worse?

☐ Inactivity ☐ Exercise (describe):_____ Other (Please describe):_____

What Treatment Have You Tried for this Injury?

☐ Nothing ☐ Exercise ☐ Ice ☐ Decreased Activity ☐ Bracing
☐ Injections (i.e. Synvisc/Hyalgan/Cortisone) (Date Started):_____
☐ Physical Therapy (Date Started):_____ ☐ Acupuncture(Date Started):_____ ☐Other: _____
☐ Medications:_____ ☐ Chiropractic(Date Started):_____

Have You Seen Another Physician for This Injury? ☐ Yes / ☐ No **Were You Referred?** ☐ Yes / ☐ No
If Yes, Who/Where? _____

Are you Interested in Surgery for this Problem? ☐ Yes / ☐ No / ☐ Unsure

Have You Had Any of the Following Tests/Studies?

Test	Date (Month/Year)	Facility? (Clinic/Hospital)
X-Ray		
MRI		
CT Scan		
EMG/NCV		
Discogram		
EKG		
Blood Tests		
Other		

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PAST MEDICAL HISTORY Please Check if You Currently Suffer or Have Previously Suffered From:

	When?		When?
High Blood Pressure		Osteoporosis	
Deep Vein Thrombosis (Blood Clot)		Kidney Disease/Problem	
Liver Disease		Seizures	
Heart Disease/Attack		Arthritis	
Stroke		Thyroid ☐ Hyper ☐ Hypo	
Cancer (where?)		Tuberculosis	
Elevated Cholesterol		Pulmonary Embolism	
Ulcer Disease		Polio	
Gastritis		Rheumatic Fever	
Reflux Disease (GERD)		Gout	
Asthma		Depression	
Diabetes		Psoriasis	
History of MRSA		COPD	
Other:		Sleep Apnea	

Do You Have a Pacemaker? ☐ Yes / ☐ No **Have You Ever Had Heart, Brain or Artery Surgery?** ☐ Yes / ☐ No

Do You Have Any Chance of Implants or Metal Savings In Your Skin? ☐ Yes / ☐ No

GASTROINTESTINAL HISTORY

Do you have a History of Peptic Ulcer Disease? ☐ Yes / ☐ No If Yes, When?_____

Do you have a History of Peptic Ulcer Disease? ☐ Yes / ☐ No If Yes, When?_____

Do You Take Any Medications for Your Stomach? (Please include Over The Counter Medications; i.e. Pepcid, Tums, Zantac, etc. Dose and Frequency)

_____

SURGICAL HISTORY

Please List ALL Surgeries to the AREA You are being Seen for Today:

Type Of Surgery	Date	Surgeon

Please List ALL Other Surgeries You Have Had in the Past:

Type Of Surgery	Date	Surgeon

Have you Ever Had a Reaction to Anesthesia? ☐ Yes / ☐ No If Yes Explain:_____

ALLERGIES

Are You Allergic to: **Sulfa Drugs?** ☐ Yes / ☐ No **Latex?** ☐ Yes / ☐ No **Steroids?** ☐ Yes / ☐ No

Please List Any Environmental Allergies:

Other Medication Allergies	What Happened?

MEDICATIONS (Please List ALL Prescription and Over the Counter Medications or Supplements)

Medication	Dosage	Frequency

SOCIAL HISTORY

Occupation:_____Are you Currently Working? ☐ Yes ☐ No ☐ Retired ☐ Limited Duty
Recreational Activities:_____ ☐ College or ☐ Pro?
Current Activity Level:_____
Tobacco Product Use: ☐ Never ☐ Smoke ☐ Chew **Freq:** ☐ Everyday ☐ Someday ☐ Occasionally ☐ Former ☐ Unknown
Alcohol Use (Drinks Per Day): ☐ 6 or More ☐ 4-5 ☐ 2-3 ☐ 1 ☐ Less Than 1 ☐ 0 In Last Year ☐ Don't Drink
Caffeine Use: ☐ Yes ☐ No Type/Frequency:_____
Recreational Drugs: ☐ Yes ☐ No Type/Frequency:_____
Is There a Chance You Could Be Pregnant? ☐ Yes / ☐ No

FAMILY HISTORY (Please Check Family History Conditions As Well As Who Had the Condition)

Blood Clots:_____Osteoporosis:_____Rheumatoid Arthritis:_____
Diabetes:_____Heart Disease:_____Hypertension:_____
Seizures:_____Stroke:_____Anesthetic Problems:_____
Cancer: _____Other:_____

REVIEW OF SYSTEMS

CONSTITUTIONAL/GENERAL ☐ None ☐ Weight Gain ☐ Weight Loss ☐ Chills ☐ Fever ☐ Weakness/Fatigue
Other:_____

EYES ☐ None ☐ Blurred Vision ☐ Glasses ☐ Contacts ☐ Eye Pain ☐ Redness
☐ Vision Change ☐ Cataracts ☐ Glaucoma
Other:_____

EARS, NOSE, THROAT ☐ None ☐ Nose Bleed ☐ Ear Ache or Infection ☐ Ringing in Ear ☐ Hoarseness
☐ Loss of Hearing
Other:_____

CARDIOVASCLAR ☐ None ☐ Chest Pain ☐ Swelling in Legs ☐ Shortness of Breath ☐ Palpitations
Other:_____

RESPIRATORY ☐ None ☐ Shortness of Breath ☐ Wheezing/Asthma ☐ Frequent Cough
Other: _____

GASTROINTESTINAL ☐ None ☐ Heartburn ☐ Vomiting ☐ Nausea ☐ Abdominal Pain ☐ Acid Reflux
Other:_____

MUSCULOSKELETAL ☐ None ☐ Arthritis ☐ Stiffness ☐ Muscle Aches ☐ Swelling of Joints ☐ Instability
Other:_____

SKIN ☐ None ☐ Rash ☐ Itching ☐ Redness ☐ Abnormal Scars ☐ Psoriasis ☐ Ulcers/Sores
Other:_____

NEUROLOGICAL ☐ None ☐ Headaches ☐ Numbness, Tingling, Loss of Sensation in ANY Body Part
☐ Dizziness ☐ Poor Balance ☐ Fainting Spells ☐ Seizures
Other:_____

PSYCHIATRIC ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety ☐ Mood Swing
Other:_____

ENDOCRINE ☐ None ☐ Excessive Thirst or Hunger ☐ Hot/Cold Intolerance ☐ Hot Flashes
Other:_____

HEMATOLOGICAL ☐ None ☐ Easy Bruising ☐ Easy Bleeding ☐ Varicose Veins ☐ Blood Clots ☐ Anemia
Other:_____

Signature:_____Print Name:_____Date:_____