Shane K. Woolf, MD

Board Certified Orthopaedic Surgeon

Charleston Sports Medicine & Orthopaedic Centers

Patient Registration & Medical Worksheet

Title: Dr. Mr. Mrs. Ms. Miss Other_____

First name: _____ Last name: _____ Middle initial _____

Address: _____

City: _____ State: _____ Zip: _____

SS#_____ Age: _____ Date of Birth: _____ Gender: M F Marital Status: M S W D

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Email: _____ Preferred method of contact: Home Work Cell Email

Occupation:_____Employer: _____

Race/Ethnicity:_____

By providing us with your e-mail address, you authorize Charleston Sports Medicine to send you periodic reminders or announcements. We will not disclose your email address to any third party. You may choose to terminate receiving e-mails from us at any time via e-mail, telephone, or in person.

Emergency Contact_____ **Relationship**_____ **Phone**_____

Spouse/significant other's Name _____**Cell Phone** _____ **Work Phone**_____

How did you hear about our practice?

- ❑ I am a former patient
- ❑ Physician – Who: _____
- ❑ Friend
- ❑ Another Patient – Who: _____
- ❑ Search engine - Which one: _____
- ❑ Other Website – Which one: _____
- ❑ Newspaper
- ❑ Magazine – Which one: _____
- ❑ Website – CharlestonSportsMed.com
- ❑ Website – shanewoolfmd.com
- ❑ Instagram
- ❑ Facebook
- ❑ Twitter
- ❑ Hospital – Which one: _____

Consent For Photographic Documentation and Video Range of Motion/Body Mechanics Measurement

I consent for medical photographs and/or video to be obtained of me before, during, and/or after visits or procedures associated with my care. These photographs and videos shall remain the property of Dr. Woolf/Charleston Sports Medicine. These images will be restricted to my medical record and may not be used for any purpose other than confidential documentation of my pre-operative and post-operative condition or my body motion mechanics. Deidentified range of motion values may be included in a database. Photos may be released to my insurance company if necessary to obtain a prior authorization for surgery. My signature below does NOT constitute permission to use the photographs or images taken for medical purposes to be used in photo albums, patient education, medical education, journal publications, or any marketing medium without specific permission. I understand that every effort will be made to maintain confidentiality of my identity.

Signature of Patient (or Responsible Party):_____ **Date** _____

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What is the reason for your visit? _____

Referring Physician _____ Primary Care Physician _____

Height _____ Weight _____

My Current Orthopaedic problem:

Upsets me a lot Gets in the way of doing things with friends Has caused problems at work Avoid certain activities because of it Think about it "all the time"

Past medical History- Have you ever had? (*Circle all that apply)*

Problems with anesthesia Bleeding problems Blood clotting problems Asthma Emphysema Pneumonia Lung Disease Anemia

Details/Dates _____

Part II- Have you ever had? *(Circle all that apply)*

Skin Cancer- Basal cell, Squamous cell, Melanoma Breast Cancer Cancer- other Chest pain/ tightness Diabetes Eczema

Details/Dates_____

Part III- Have you ever had? (*Circle all that apply)*

High Blood Pressure Heart Disease/ Heart Attack Arrythmias/ Irregular heartbeat Mitral Valve Prolapse Heart Murmur Hepatitis Liver Disease

Details/Dates_____

Part IV- Have you ever had? (*Circle all that apply)*

Stroke Thyroid Disorder Tuberculosis Radiation Therapy HIV/ AIDS Depression Anxiety Bipolar Disorder Borderline Disorder

Emotional problems- other

Details/Dates_____

Part V- Have you ever had? (*Circle all that apply)*

Arthritis- rheumatoid, degenerative, traumatic Gout Stomach Disease- including ulcers Substance abuse History of blood transfusions Sleep apnea

Other medical problems_____

Details/Dates_____

Past Surgeries	**Date**	**Notes**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Current Medications	Dose	How often taken?	Prescribed by?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Supplements/Vitamins

- ❑ Please List: _____

Do you smoke? Yes No/Quit Packs per day_____ When did you quit? _____

Chewing Tobacco/Gum Yes No

Do you exercise? Yes No Type_____ How many times per week?_____

Family History
(Circle all that apply)

Abnormal bleeding Abnormal clotting Anesthesia Problems Malignant Hyperthermia
Autoimmune disorders Breast cancer Cancer- other Endocrine disease Heart disease
High blood pressure

Details:_____

Are you allergic or sensitive to any of the following (Circle all that apply)?

Latex Penicillin Adhesive tape Codeine Sulfa drugs Erythromycin Other_____

What happens? _____

Women Only

Is there a chance you may be pregnant (important to let us know if you may need X-rays or surgery)? **Yes** **No**

Immunization History	Date last given	Details
Tetanus shot		
Flu vaccine		
Pneumonia vaccine		
Hepatitis vaccine		
Covid Vaccine/Booster		

Other: _____