PATIENT INFORMATION

Name: ____ DOB: _______________ Age: _______ Gender: _________

Address: ____City: ___________________Zip: _______________

Home Phone: ________________________ Cell Phone: ________________________ Ethnicity: ___________________

Email: ____

Occupation: ____Employer: ____

Marital Status (check one): ___Single ___Married _ Separated Divorced ___Widow ___Other

How did you hear about us? ____

EMERGENCY CONTACT

Permission to contact?	Name	Relationship	Phone Number	Release Routine Info	Release Sensitive Info
O Yes O No				O Yes O No	O Yes O No
O Yes O No				O Yes O No	O Yes O No

PERSONAL HEALTH HISTORY

Height: ______________ Weight: _____________ Shoe Size/Width: ________________

What brings you to the office today? ____

Pain scale (0-10, 10 being the worst): ________ How long has pain been present? __________________________

What have you tried? ____

Do you spend more than 50% of your day standing? ____________

Are you on blood thinners? ________ If so why? ____

Do you have knee, hip, or back problems? ____________ If so, which ones? ______________________________

Do you have swelling or pain in your limbs? ______ If so, where? ____________________ How long? ___________

Past Surgeries/Hospitalization: ____

Food/Drug Allergies & Reactions: ____

Current Medications (including prescriptions, non-prescriptions, over the counter, and herbals):

____

FOUNDATION
FOOT & ANKLE CENTER

MEDICAL HISTORY

Cardiovascular
___ High blood pressure
___ Low blood pressure
___ Congestive heart failure
___ Heart attack
___ Stroke/CVA
___ Pacemaker or similar device
___ Heart disease
___ Chest pain

Infections
___ Hepatitis
___ Skin conditions
___ Tuberculosis
___ HIV/AIDS
___ Herpes

Respiratory
___ Chronic cough
___ Shortness of breath
___ Bronchitis
___ Asthma
___ Emphysema

Other Conditions
___ Arthritis
___ Back problems
___ Bleeding/Clotting disorder
___ Cancer, where? ____________________
___ Deep vein thrombosis
___ Epilepsy
___ Foot/leg ulcers

___ Gout
___ Kidney disease
___ Liver disease
___ Peripheral vascular disease
___ Diabetes, onset? ________
HgA1c?____________
Loss of sensation, where? ______________________

Women
___ Pregnancy, due date: ____________________
___ Gynecological conditions, what? ____________________

SOCIAL HISTORY

Do you smoke? O Yes, current smoker O No, former smoker O No, never smoked

If yes, how long? ____________ How much per day? ____________ If former, when quit? ______________

How often do you drink? O Never O Socially O Moderately O Heavily

Do you use any recreational drugs? __________ If yes, what do you use? __________________________________

FAMILY MEDICAL HISTORY

Mother: _________________________ Father: _________________________ Siblings: __________________________

Maternal Grandmother: _____________________________ Maternal grandfather: _____________________________

Paternal Grandmother: ______________________________ Paternal grandfather: ______________________________

PROVIDER AND PHARMACY

Primary Care Physician: ____ Last Visit: _________________

Address: ____Phone: __________________Fax: _________________

Pharmacy & Address: ____

SIGNATURE

Printed Name: ____ Date: _________________________

Signature: ____ Relationship: _________________________

FOUNDATION
FOOT & ANKLE CENTER