

# Foot & Ankle Specialists

of the *Mid-Atlantic*

*Keeping you on track...For Life!*

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Age \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Reason for your visit: \_\_\_\_\_

How long has this been a problem? \_\_\_\_\_ When does it occur? Morning Afternoon Evening Off and On All Day

Please list previous treatments (either prescribed or home remedies): \_\_\_\_\_

List sports/activities that you are currently active in: \_\_\_\_\_

Do you have a history of allergies/skin reaction/sickness following the administration of any of the following:

	Y	N	** If yes, list REACTION		Y	N	** If yes, list REACTION
Adhesive tape	___	___	_____	Foods	___	___	_____
Anesthesia	___	___	_____	Iodine	___	___	_____
Aspirin	___	___	_____	Latex	___	___	_____
Caffeine	___	___	_____	Local Anesthetics	___	___	_____
Codeine	___	___	_____	Penicillin	___	___	_____
Cortisone	___	___	_____	Sulfa Drugs	___	___	_____
Demerol	___	___	_____	Other, please list: _____			

Please list or provide a list of your current medications and their dosages:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medical History:** please circle **P (personal history)** and/or **F (family history)**.

- |   |  |   |
|---|--|---|
| P F Alcohol/Drug addiction/dependency                                   | P F Headaches / Migraines headaches      | P F Schizophrenia                       |
| P F Alzheimer's / Dementia  | P F Hearing Problems                     | P F Seizures/ Epilepsy                  |
| P F Anemia - type _____   | P F Heart Disease                        | P F STD's (sexually transmitted ds.)    |
| P F Arrhythmias - type _____  | P F Hepatitis A B C /Liver Disease _____ | P F Sickle Cell Trait/Disease           |
| P F Arthritis - type _____  | P F High Blood Pressure                  | P F Stroke/ TIA's                       |
| P F Asthma <u>circle</u> ( adult or childhood)                          | P F High Cholesterol                     | P F Thyroid problems<br>(Hyper__Hypo__) |
| P F Bleeding/Clotting Problems. Type?                                   | P F HIV/ Aids/ ARC                       | P F Tuberculosis                        |
| P F Cancer - type _____   | P F Kidney/ Renal Disease                | P F Other, Please Specify _____         |
| P F Depression / Anxiety disorder /<br>Bipolar depression / other _____ | P F Lung Disease/Pulmonary Embolus       |   |
| P F Diabetes (how long? _____)  | P F Lyme's Disease                       | P F Other, Please Specify _____         |
| P F Emphysema / COPD  | P F Nervous Condition (type?) _____      |   |
| P F Glaucoma  | P F Osteoporosis / Osteopenia (circle)   |   |
| P F Gout  | P F Phlebitis (blood clots in legs)      |   |
| P F GERD (Reflux) / GI ulcers (circle)                                  | P F Poor Circulation / PVD               | P F <b>NONE of the above</b>            |
|   | P F Rheumatic Fever / Scarlet Fever      |   |

**Have you been hospitalized? Y N Please list**

**Have you ever had surgery? Y N Please list**

**Social History: PLEASE FILL OUT COMPLETELY**

**SMOKING:**

Do you or have you ever smoked? YES NO

If yes, how many years? \_\_\_\_\_

How long ago did you quit? \_\_\_\_\_

**ALCOHOL USE:**

Do you or did you ever drink alcoholic beverages? YES NO

How many drinks will you consume in a day? \_\_\_\_\_ week? \_\_\_\_\_

How long ago did you quit? \_\_\_\_\_

**RECREATIONAL DRUG USE:**

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

If yes, which ones \_\_\_\_\_

How long ago did you quit? \_\_\_\_\_

**Woman:** Are you currently pregnant? YES NO Due date? \_\_\_\_\_

**Consent for Treatment:**

I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. I give permission to Dr. \_\_\_\_\_ to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

\_\_\_\_\_  
 Patient or Guardian Signature

\_\_\_\_\_  
 Date