Patient's Name: _____ **Date of Birth:** _____

REASON FOR VISIT

Please describe your present foot or ankle concerns, problems or symptoms:

1. _____
2. _____

Have you ever been seen by a foot and ankle doctor? ☐ Yes ☐ No

If yes, for what reason? (Please include who and when.) _____

_____

MEDICAL HISTORY

When was your last physical exam? _____

Family doctor's first and last names: _____ Phone #: (____) _____

1. Are you currently under medical treatment? ☐ Yes ☐ No

If yes, for what? _____

2. Care Team: List other specialists you see such as cardiologists, dermatologists, endocrinologist, etc.

Type of Specialist	**Name and Contact Info**
_____	_____
_____	_____
_____	_____

3. Please check any of the following to which you've had allergic reactions: ☐ **NONE**

☐ Adhesive Tape ☐ Iodine ☐ Penicillin

☐ Aspirin ☐ Latex ☐ Sulfa

☐ Codeine ☐ Local Anesthetics (Novocaine)

☐ Other (please explain): _____

4. Are you currently taking any prescription or over-the-counter medications? ☐ Yes ☐ No

☐ I have brought an updated list of medications with me.

If you answered "yes" and you didn't bring an updated list, please list them:

Name of Medication and Dosage **(e.g. Lisinopril 10 mg)**	**Reason for Medication** **(e.g. Diabetes)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. Local pharmacy, location and phone #: _____

Mail order pharmacy: _____

Patient's Name: _____ **Date of Birth:** _____

MEDICAL HISTORY (CONTINUED)

6. Have *YOU* ever had the following? (Please check all that apply.)

- ☐ Acid Reflux
- ☐ Anemia (Low Blood Count)
- ☐ Anxiety
- ☐ Arthritis Type: _____
- ☐ Asthma
- ☐ Blindness
- ☐ Blood Clots in Leg (i.e. DVT)
- ☐ Blood Clots in Lung (i.e. Pulmonary Embolism)
- ☐ Cancer Type: _____
- ☐ Chemotherapy
- ☐ Chronic Fatigue Syndrome
- ☐ COPD (Emphysema)
- ☐ Depression
- ☐ Diabetes ☐Type 1 ☐ Type 2
  How Long: _____
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Hard of Hearing
- ☐ Hardening of Arteries
- ☐ Heart Disease
- ☐ Heart Murmur (e.g. AFib, VFib)
- ☐ Hepatitis A B C D (circle one)
- ☐ Herniated Disc (What level? _____)
- ☐ High Blood Pressure (i.e. Hypertension)
- ☐ High Cholesterol (i.e. Hyperlipidemia)
- ☐ HIV/AIDS
- ☐ Low Blood Sugar (i.e. Hypoglycemia)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Peripheral Arterial Disease
- ☐ Phlebitis
- ☐ Polio
- ☐ Psoriasis
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Spinal Stenosis
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Function ☐ High ☐ Low
- ☐ Tuberculosis ☐ Active ☐ Inactive
- ☐ Varicose Veins
- ☐ Vitamin D Deficiency
- ☐ Other (please explain): _____

☐ **NONE**

7. Have *YOU* ever had surgery? ☐ Yes ☐ No

- ☐ Foot/Ankle Surgery, please describe: _____
- ☐ Appendix
- ☐ Bypass Surgery ☐ Heart ☐ Leg
- ☐ Catheterization (Heart)
- ☐ Gall Bladder
- ☐ Gastric Bypass or Lap Band (circle one)
- ☐ Hysterectomy
- ☐ Joint Replacement (Which? _____)
- ☐ Orthopedic (Body area? _____)
- ☐ Pacemaker/Defibrillator (circle one)
- ☐ Stents ☐ Heart ☐ Leg
- ☐ Tonsils
- ☐ Other _____

Patient's Name: _____ **Date of Birth:** _____

MEDICAL HISTORY (CONTINUED)

8. Has *any member of your immediate family* been treated for the following? ☐ **UNKNOWN**
(Please check all that apply AND circle the appropriate family member.) ☐ **NONE**
F = father M = mother B = brother Si = sister So = son D = daughter

☐ Arthritis	F	M	B	Si	So	D	☐ Heart Disease	F	M	B	Si	So	D
☐ Cancer	F	M	B	Si	So	D	☐ High Blood Pressure	F	M	B	Si	So	D
☐ Diabetes	F	M	B	Si	So	D							

9. What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

10. What is your occupation? _____ ☐ Retired

11. Do you smoke or use tobacco products? ☐ Formerly ☐ Never ☐ Yes: How much per day: _____

12. Do you vape? ☐ Yes ☐ No

13. Do you use illegal drugs? ☐ Yes ☐ No

14. How many alcoholic drinks do you consume per week? _____ drinks per week

15. Do you have or are you subject to any of the following? (Please check all that apply.)

☐ Fever/Chills	☐ Back Pain
☐ Chest Pain	☐ Balance Problems
☐ Cold Feet	☐ Foot/Leg Cramps
☐ Foot/Leg Pain that Wakes You Up at Night	☐ MRSA or VRE Infection (previous)
☐ Swelling of Legs	☐ Burning Pain/Tingling/Numbness
☐ Varicose Veins	☐ Fainting
☐ Shortness of Breath at Rest	☐ Bleeding/Clotting Disorder
☐ Shortness of Breath When Active	☐ Bleeding Tendency
☐ Nausea/Vomiting	☐ Prolonged Bleeding

☐ **NONE**

I CERTIFY THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____