PATIENT HISTORY

foot & ankle

Name

Date of Birth | Age

Height | Weight | Shoe Size

Marital Status:
❑ single ❑ married ❑ divorced ❑ partnered ❑ separated

Phone | E-Mail

Primary Care Physician

Location

Referring Provider *(or how did you hear about us?)*

Location

Please describe the problem you are experiencing:

When did this problem begin/how long have you had it?

Did this problem develop as a result of a specific injury?
❑ yes ❑ no

Did this problem result from a work injury?
❑ yes ❑ no

Have you seen other physicians for this problem?
❑ yes ❑ no Who?

What tests or treatments have you had for this problem?

If you have had previous procedures
related to this problem, when?

Past Medical History/System Review *(check positives)*

- ❑ headaches
- ❑ neck problems
- ❑ glaucoma
- ❑ dentures
- ❑ sinus problems
- ❑ heart disease
- ❑ pacemaker/defibrillator
- ❑ high blood pressure
- ❑ rheumatic fever
- ❑ stroke
- ❑ poor circulation
- ❑ asthma
- ❑ sleep apnea
- ❑ COPD/emphysema
- ❑ heartburn/GERD
- ❑ ulceration

- ❑ constipation/diarrhea
- ❑ hepatitis A B C
- ❑ liver/gall bladder problems
- ❑ kidney disease
- ❑ bladder disease
- ❑ arthritis--degenerative
- ❑ arthritis--rheumatoid
- ❑ arthritis--psoriatic
- ❑ osteoporosis
- ❑ gout
- ❑ epilepsy/seizures
- ❑ neurologic condition
- ❑ bleeding disorder
- ❑ blood clots
- ❑ anemia
- ❑ transfusions

- ❑ HIV/AIDS
- ❑ Diabetes # years ______
  - ❑ diet control
  - ❑ oral med
  - ❑ insulin
- ❑ thyroid disease
- ❑ psychiatric disorder:
- ❑ chemical dependancy
- ❑ alcoholism
- ❑ skin condition
- ❑ keloid/hypertrophic scar
- ❑ pregnancy
- ❑ births ______
- ❑ last tetanus ______
- ❑ problems with anesthesia
- ❑ cancer - type ______

Details of any of the above:

Details regarding *any* significant health related events during the past 6 months:

If cardiac history, please provide your cardiologists contact information:

Past Surgeries/Hospitalizations

Date	Procedure/Reason	Complications

Current Medicines

Medication	Dosage	Frequency	Medication	Dosage	Frequency

**Please use the back of this form if you need to add more medications.*

Allergies

Allergen/Medication	Reaction

Family History ***(include foot and ankle problems, anesthesia reactions, medical conditions)***

Grandparents: ____________________

Father: ____________________

Mother: ____________________

Siblings: ____________________

Social History

Occupation: ____________________

Shoe type: ____________________

Regular exercise? ❏ yes ❏ no Type: ____________________

Date of Last Physical Exam? ____________________

Performed by? ____________________

Smoking? ❏ yes ❏ no ❏ quit

packs per day? ________ How long? ________

If quit, when? ____________________

Alcohol? ❏ yes ❏ no ❏ quit

Number drinks per week? ____________________

If quit, when? ____________________

Recreational drugs? ❏ yes ❏ no

Narcotic drug abuse? ❏ yes ❏ no