Foot & Ankle Specialty Clinic

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Patient Information

Name_____ DOB_____

Height_____ Weight_____

Shoe Size_____

Flu Shot (date)_____Pneumonia Shot (date)_____

Are you diabetic: Y N

If you are a diabetic, please answer the following:

Who is the doctor that monitors your diabetes?

_____

What was the date of your last visit?_____

What was your last A1C?_____

What was your last blood sugar?_____

Do you wear Diabetic Shoes? **Y N**

When was your last pair of Diabetic Shoes ordered?

_____

Do you have any allergies? Y N

Allergies (circle all that apply)

Adhesive Tape	Morphine	Sulfa Drugs
Aspirin	Penicillin	Latex
Chemicals	Food	Codeine

Antibiotics_____

Other_____

_____

_____

_____

Family History

Has anyone in you family had any of the following, and if so, who and when did this occur?

Condition	***Family Member***	***Date***
Cancer (type)	_____	_____
Diabetes (type)	_____	_____
Stroke	_____	_____
Arthritis	_____	_____
Heart Attack	_____	_____

Social Histoy

Do you drink alcohol? Yes No Quit - Date_____

Do you smoke? Yes No Quit - Date_____

If yes, how many packs a day?_____

How many years have you smoked?_____

Do you chew tobacco? Yes No Quit - Date_____

Do you use recreational drugs? Yes No Quit - Date_____

If female - Are you pregnant? Yes No

Medication

Please list all medications you are currently taking or which pharmacy you use.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you ever had MRSA? Yes No

Surgeries

Have you had any surgeries? Yes No

If yes, list surgery and date.

Surgery:_____

Date:_____

Surgery:_____

Date:_____

Surgery:_____

Date:_____

Surgery:_____

Date:_____

Review of Systems

Conditions you have had in the PAST. (circle)

Stiffness
Anxiety
Arthritis
Asthma
BPH
Back Issues
Bleeding
Bruising
CAD
Cancer
Cardiac Issues
High Cholesterol
COPD
Cough
Dementia
Depression
Dermatitis
Diabetes
  Type 1
  Type 2
Dizziness
Dry Skin
Dry Mouth
Edema
Fainting
GERD
Gout
HIV
Headache
Hepatits
Hypertension
Joint Pain
Lesion/Sore
Migraine
Numbness
Pneumonia
Raynauds
Seizure
Stiffness
Stroke
TB
Thyroid
Ulcer
_____
_____

Circle any of the following conditions you currently have.

Constitution
Chills
Fatigue
Weakness
Fever
Weight Gain
Weight Loss
Delayed healing to skin

Head
Dizziness
Headaches
Fainting
Pain
Head Injury
Sweats

Respiratory
Asthma
Bronchitis
Cough
Short Breath

Cardio
High Blood Pressure
Swelling of Legs
Varicose Veins
History of heart attack
Ulcers on Legs

Gastro
Abdonminal Pain
Stomach Issues
Diarrhea

Muscular/Skeletal
Arthritis
Gout
Back Problems
Joint Pain
Deformities
Muscle Stiffness
Weakness
Joint Stiffness
Paralysis

Limb Length Discrepancy

Skin
Exzema
Dermatits
Nail Change
Itchy Skin

Neuro
Burning
Unsteady Gait
Restless Leg
Neuropathy
Parkinson's

Endocrine
Weight Change
Fatigue

Hematologic
Anemia
Bruise Easily
Blood Clots

Other
_____
_____