VITTORI FOOT & ANKLE SPECIALISTS DR CHRISTOPHER M VITTORI

DATE: _____

Name: _____ Telephone: _____

Height: _____ Weight: _____ Age: _____ Sex: _____ Shoe Size: _____

How did you hear of Dr. Vittori?:_____

What brings you to our office?: _____

PRIMARY CARE PHYSICIAN(s): _____

General Health: GOOD FAIR POOR Are you pregnant? Y N

Do you have diabetes? _____ Last Blood Sugar: _____ Diabetes in Family: _____

Do you have pain, cramps, numbness, swelling, tingling in your feet or legs? Y N
Explain: _____

Do you bruise easily? Y N Do you have low back pain? Y N Do you have any implants? Y N

CURRENT MEDICATIONS WITH DOSAGE:
List: _____

PREFERRED
PHARMACY_____Address_____City_____

Do you smoke? Y N How much? _____ Do you drink? Y N How much? _____

PAST SURGERY: _____

PAST HOSPITALIZATION: _____

MEDICATION ALLERGIES/ALLERGIES: Y N
List: _____

FAMILY HISTORY/ROS:

	Patient	Family/Who	Living/Deceased
Heart Trouble			
High Blood Pressure			
Kidney Problems			
Lung Problems			
Asthma			
Stomach/Bowel			
Liver Problems			
Circulation			
Varicose Veins			
Epilepsy/Seizures			
Arthritis			
Cancer			
Bleeding Problems			
Depression			
Other			

Date of last flu shot_____

History of falls_____

DATE: _____ SIGNED _____