Ankle and Foot Clinic of Idaho Name: ____________________________ Birthdate: ____________

Briefly describe your problem:		
Accident/Injury Related? YES ☐ NO ☐	If yes, was it work related? YES ☐ NO ☐	Date of Injury:

Medical History: Are you or have you ever been treated for the following:

☐ Arthritis Type:	☐ Extremity Injury/ Deformity	☐ High Cholesterol	☐ Neuropathy
☐ Asthma	☐ Foot / Leg Ulcer	☐ Hypothyroid	☐ Osteoporosis
☐ Bronchitis	☐ DVT	☐ Kidney Disease	☐ Peripheral vascular disease
☐ Cancer Type:	☐ Heart Attack	☐ Liver Disease	☐ Seizures
☐ COPD	☐ Heart Failure	☐ Lung Disease	☐ Sleep Apnea
☐ Coronary Artery Disease	☐ Hepatitis	☐ MRSA	☐ Stomach Problems/ Reflux
☐ Emphysema	☐ High Blood Pressure	☐ Migraines	☐ Stroke
☐ Diabetes How Long?	Average glucose range?	☐ Gout	☐ Other:

Medication ☐ **NONE**	**DOSE**	**Times/day?**	**Allergies** ☐ **NONE**	
1)			☐ Latex ☐ Tape ☐ Anesthetic ☐ Seafood	
2)			Reaction:	
3)			**Drug Allergies**	**Reaction**
4)			1)	
5)			2)	
6)			3)	
7)			4)	

Past Surgeries ☐ **NONE**	**Year**	**Complication?**	**Social History**
1)			☐ Single ☐ Married ☐ Divorced ☐ Widowed
2)			Occupation:
3)			☐ Alcohol How Much?
4)			☐ Recreational Drugs Type:
5)			☐ Tobacco Packs/day: How long?
6)			If quit, when did you do so?

Family History: **Please indicate**: **GF**=Grandfather **GM**=Grandmother **F**=Father **M**=Mother **S**=Sibling

☐ Father Deceased Cause:	☐ Mother Deceased Cause:	
Cancer: Type:	Heart Attack:	Bleeding Disorder:
Diabetes:	Foot Problems:	Birth Defects:
High Blood Pressure:	Lung Disease:	Stroke:

Review of Systems: Have you recently had any of the following symptoms? (Blank indicates "No Problem")

General: ☐ Wt. Loss ☐ Wt. Gain ☐ Fever ☐ Night Sweats	Skin: ☐Rash ☐ Itching ☐ Open sores Where:
Eyes/Ears: ☐ Vision Loss ☐Double Vision ☐Hearing Loss	Neuro: ☐ Numbness/Tingling ☐ Frequent Headaches
Nose/Throat: ☐ Sinus Problems ☐ Nasal Drainage ☐ Sore Throat	Endocrine: ☐ Cold intolerance ☐ Excessive hunger/thirst
Heart: ☐ Chest Pain ☐ Palpitations ☐ Murmur	M/S: ☐ Pain: ☐ Muscles ☐ Neck ☐ Back ☐ Hips ☐ Knees
Lungs: ☐ Shortness of Breath ☐ Cough ☐ Wheezing	☐ Cramping ☐ Stiffness ☐ Weakness
GI: ☐Stomach Pain ☐Constipation ☐Diarrhea ☐Vomiting	Psych: ☐ Anxiety ☐ Depression ☐ Memory Loss
GU: ☐Frequent urination ☐ Painful urin. ☐ Difficult urin.	Hematology: ☐ Anemia ☐ Excessive Bleeding ☐ DVT

Signature: Date: