BRANDYWINE
FOOT & ANKLE ASSOCIATES

Welcome!

To Brandywine Foot & Ankle Associates

Patient Name: _____ _____ _____
LAST MI FIRST

Date of Birth: _____ Race: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Cell Home Work **Cell Phone Carrier**: _____

Secondary Phone: _____ Cell Home Work

E-Mail Address: _____

Primary Care / Family Doctor:

Name: _____ Location: _____

Phone Number: _____ Date of Last Appointment: _____

Are you Diabetic? YES NO

Name of Diabetic Doctor: _____ Date of Last Appointment: _____

Employment:

Circle One: Employed Unemployed Full-time Student Part-time Student Retired Child Other

Employer/School: _____ Occupation: _____

Emergency Contacts:

Name: _____ Relationship to Patient: _____

Phone Number: _____ E-Mail: _____

Pharmacy:

Name: _____ Phone Number: _____

Location: _____

Patient Name: _____ DOB: _____

Reason for today's visit: _____

Height: _____ Weight: _____ Shoe Size: _____

Have you EVER had, or do you FREQUENTLY HAVE, any of the following? Please check all that apply.

Constitutional

☐ Chills	☐ Fatigue	☐ Fever
☐ Weakness	☐ Weight Gain	☐ Weight Loss

Cardiovascular

☐ Chest Pain	☐ Varicose Veins	☐ Extremity(s) Cool
☐ Hair Loss on Legs	☐ Heart Murmur	☐ High Blood Pressure
☐ Rheumatic Fever	☐ Cramps in Legs/Feet	☐ Congestive Heart Failure
☐ Leg or Foot Ulcers	☐ Palpitations	☐ Replacement Heart Valve
☐ Vascular Grafts	☐ Stent(s)	☐ Defibrillator Pacemaker

Musculoskeletal

☐ Joint Pain	☐ Orthotic Use	☐ Lower Back Pain
☐ Knee Pain	☐ Joint Stiffness	☐ Muscle Cramps
☐ Back Problems	☐ Bunions	☐ Weakness
☐ Paralysis	☐ Corns	☐ Broken Ankle
☐ Childhood Foot Problems	☐ Hammer/Mallet Toes	☐ Calluses
☐ Gait (Walking) Problems	☐ In-Toeing	☐ Flat Feet
☐ High Arch	☐ Neuroma	☐ Heel Pain
☐ Muscle Stiffness	☐ Toe Walking	☐ Joint Implants
☐ Shoe Insert Use		

Skin

☐ Eczema	☐ Itching	☐ Warts
☐ Dryness	☐ Hives	☐ Lumps
☐ Athlete's Foot	☐ Fungal Nails	☐ Ingrown Nails
☐ Keloid Scar	☐ Mole Changes	☐ Rash

Neurological

☐ Burning	☐ Fainting	☐ Numbness
☐ Speech Disorders	☐ Stroke(s)	☐ Tingling
☐ Tremors	☐ Unsteady Gait	☐ Blackouts
☐ Charcot Neuropathy	☐ Neuromas	

Patient Name: _____ DOB: _____

Do you CURRENTLY have or have you been treated for the following medical conditions? Please check all that apply.

☐ Anemia	☐ Headache	☐ Dermatitis
☐ Anxiety	☐ Migraine	☐ Thyroid Disease
☐ Depression	☐ Epilepsy/Siezures	☐ GERD (Acid Reflux)
☐ Dementia	☐ Arthritis	☐ Ulcer (GI)
☐ Hypertension	☐ Gout	☐ Renal Stone
☐ High Cholesterol	☐ Pneumonia	☐ Benign Prostatic Hyperplasia
☐ Coronary Artery Disease	☐ Asthma	☐ Cancer
☐ Heart Attack	☐ COPD	☐ Breast Cancer
☐ Stroke	☐ TB	☐ HIV
☐ Diabetes	☐ Glaucoma	☐ Hepatitis A B C D E

Other Medical Conditions:

_____

_____

_____

_____

Tobacco Usage:

Type	Usage Status	Last Used	Daily Usage	Years Used
Cigarettes	Never / Quit / Current	_____	_____ Packs	_____
Cigars	Never / Quit / Current	_____	_____ Cigars	_____
Pipe	Never / Quit / Current	_____	_____	_____
Chewing Tobacco	Never / Quit / Current	_____	_____	_____
Dipping Tobacco	Never / Quit / Current	_____	_____	_____

Alcohol Usage:

Type	*Usage Status
Beer	Never / Social / Occasional / Light / Heavy
Wine	Never / Social / Occasional / Light / Heavy
Hard Liquor	Never / Social / Occasional / Light / Heavy

*Heavy use is defined as: > 7 standard drinks per week or > 3 drinks per occasion for women and persons > 65 years of age; > 14 standard drinks per week or > 4 drinks per occasion for men ≤ 65 years of age

Surgical History:

_____

_____

_____

_____

Patient Name: _____ DOB: _____

Medications:

Medication	Dosage	Times Per Day

Allergies to Medication:

Medication	Severity	Reaction

Family History:

	Alive Y/N	Age	Cancer	Diabetes	Heart Disease	High Blood Pressure	Other
Mother							
Father							

Who may we thank for referring you? _____

Thank you for taking the time to complete this form in its entirety!