ANKLE & FOOT SURGERY, LLC

Patient Identification and Contact Information

Name: MI: Last Name:

Phone Numbers:
Home: _____
Cell: _____
Work: _____

Home Address:

City: | State: | Zip Code: | Job or Occupation:

Sex: F / M | Age: | Birth Date: / / | Shoe Size: | Height | Weight

Primary Dr. Name_____ City_____ Phone_____

Comprehensive Patient Medical History

Have you had / been treated for:

- O Corn / calluses
- O Leg or foot ulcers
- O Broken foot / ankle bone(s)
- O Hammer / Mallet toes
- O Cramps in legs/feet
- O Gait (Walking) problems
- O Childhood foot problems
- O Other foot problems
- O Ankle sprain
- O High Arch feet
- O Warts
- O Fungal nails
- O Neuroma
- O Bunions
- O Arch Pain
- O Knee Pain
- O Athlete's Foot
- O Ingrown nails
- O Foot Numbness
- O Flat feet
- O Heel pain
- O *None of these*

Health History

List relationship to you of family members who have had:
Foot Problems _____
Arthritis _____
Diabetes _____
Poor Circulation _____
Other_____
Are you currently pregnant Yes / No
Are you slow to heal after cuts? Yes / No
Any abnormal bruising, bleeding or scarring? Yes / No
Do you smoke now? Yes / No
Packs/Day_____ Years_____
Did you ever smoke? Yes / No
Packs/Day_____ Years_____
If you quit when did you do so? _____

Alcoholic beverages (circle one)
None Rare Moderate Daily Quit

Recreational Drugs (circle one)
None Rare Moderate Daily Quit

Allergies: Is there a history of skin reactions or other outward reaction or sickness following an injection, oral or topical administration?
_____

Do you have or have you ever been treated for:

- O Stroke
- O Phlebitis
- O Diabetes
- O Gout
- O Sciatica
- O Arthritis
- O Epilepsy
- O Anemia
- O *Asthma*
- *Cancer*
- O Heart Attack
- O Poor Circulation
- O Osteoporosis
- O Liver Disease
- O Kidney Disease
- O Lung Disease
- O Stomach Ulcer
- O Alzheimer's
- O *Tuberculosis*
- O HIV or AID's
- O Nerve Disorder
- O Psychiatric Disorder
- O Hearing / Ear Disorder
- O High Blood Pressure
- O A Heart Condition
- O Eyes: Glaucoma
- O Eyes: Macular Degeneration
- O Thyroid Problem
- O *Hepatitis*
- O NONE OF THESE

Other(s)

Do you have Vascular Grafts (if yes explain below) Yes / No
Do you have Joint Implants? (if yes explain below) Yes / No
Do you have replacement heart valves? Yes / No
Are you now under active chemotherapy? Yes / No
Have you had any other serious injury? Yes / No
Have you had any Surgery (if yes explain below) Yes / No

Had Surgery for	Date	w/Complications of:

Do you suffer from Foot Pain? Yes / No
If yes please answer the questions below:

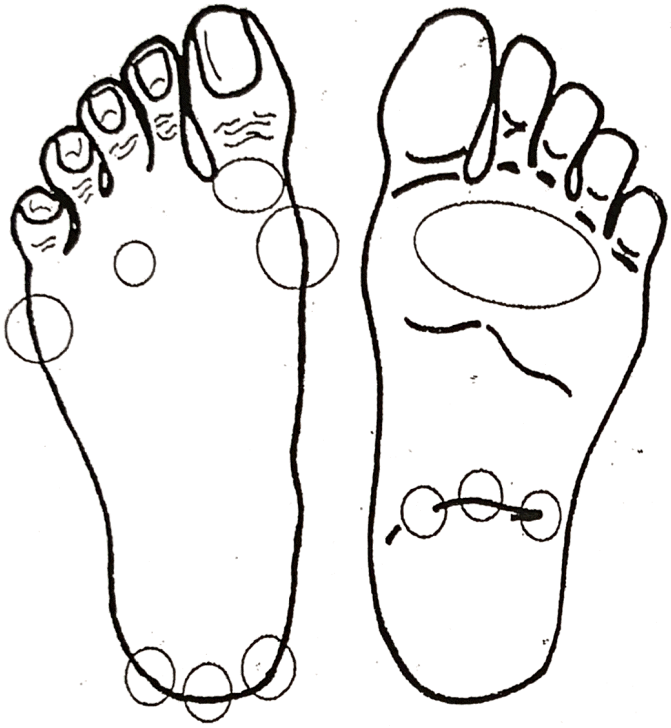
Does foot pain limit your desired activities?
Yes / No
How long have you had the pain?
_____
Previous Treatment:
_____
Describe the Problem.
_____
Cause of Pain:
_____
Scale of Pain (Circle)
1 2 3 4 5 6 7 8 9 10

ANKLE & FOOT SURGERY, LLC

List any and all your medications below:			
Name of Medication	Dose	How Often?	For Treatment of?

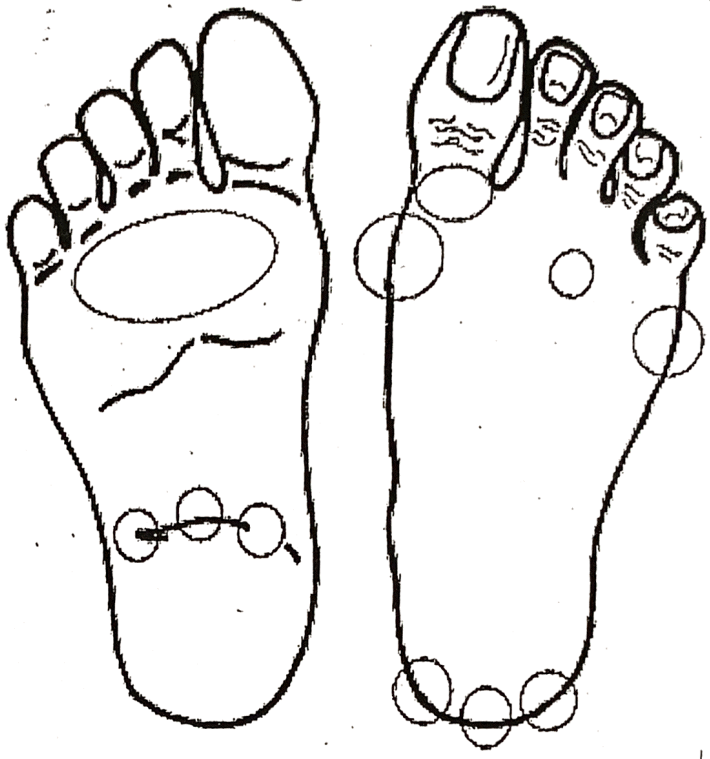
Please indicate the location of problem or pain:

Left Foot



Please indicate the location of problem or pain:

Right Foot



Describe problems for Left Foot here:	Describe problems for Right Foot here:

Please do not write below this line