



**Welcome to our practice!**

*In order to provide you the best care possible, please complete the following information...*

Whom may we thank for referring you? \_\_\_\_\_

If not referred, how did you find out about our practice? \_\_\_\_\_

What is your primary foot and/or ankle problem? \_\_\_\_\_

\_\_\_\_\_

Date symptoms began: \_\_\_\_\_ Are your symptoms worsening over time? \_\_\_\_\_

Have you been treated for this condition in the past? (If yes, by whom?): \_\_\_\_\_

Please describe all previous foot & ankle treatments (i.e. over the counter pads, injections, surgeries, etc):

\_\_\_\_\_

\_\_\_\_\_

**Are there any other foot or ankle problems you would like to discuss with the Doctor?:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Bunion              | <input type="checkbox"/> Ankle Instability | <input type="checkbox"/> Nail Discoloration |
| <input type="checkbox"/> Hammer Toes         | <input type="checkbox"/> Gout              | <input type="checkbox"/> Leg Pain/Cramping  |
| <input type="checkbox"/> Ankle Pain/Swelling | <input type="checkbox"/> Heel Pain         | <input type="checkbox"/> Numbness in Feet   |

**Patient Medical History**

Current Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Height: \_\_\_\_\_

Primary Physician \_\_\_\_\_ Office Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

Date of Last Tetanus (if known): \_\_\_\_\_

Other Treating Physicians (any condition)? \_\_\_\_\_

*Have you ever been treated for any of the following illnesses? (if yes, please check)*

Diabetes (If yes, for how long? \_\_\_\_\_ Ave blood sugar: \_\_\_\_\_ Recent A1c: \_\_\_\_\_)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Immunodeficiency Disease or HIV    | <input type="checkbox"/> Liver Disease             |
| <input type="checkbox"/> Heart Disease/Heart Attack      | <input type="checkbox"/> Thyroid Problems                   | <input type="checkbox"/> Kidney Disease            |
| <input type="checkbox"/> Stomach or Bowel Problems (IBS) | <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Emphysema/Bronchitis/Asthma     | <input type="checkbox"/> Arthritis (Type: Osteo, RA, Other) | <input type="checkbox"/> Neurological Problems     |
| <input type="checkbox"/> Depression                      | <input type="checkbox"/> Ulcers                             | <input type="checkbox"/> Circulation Problems      |
| <input type="checkbox"/> Epilepsy/Seizures               | <input type="checkbox"/> Stroke                             | <input type="checkbox"/> Back Pain                 |
| <input type="checkbox"/> TB                              | <input type="checkbox"/> Hepatitis (A or B or C?)           | <input type="checkbox"/> Joint Replacement         |
| <input type="checkbox"/> Big Scars / Keloids             | <input type="checkbox"/> Phlebitis / Blood Clots            | <input type="checkbox"/> Heart Valves or Pacemaker |
| <input type="checkbox"/> Fibromyalgia                    | <input type="checkbox"/> Bleeding Disorders                 | <input type="checkbox"/> Other: _____              |

Please comment on any illness checked above or write in other conditions not listed: \_\_\_\_\_

**MEDICATIONS** (prescriptions, over-the-counter medications, and supplements):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES** (i.e. iodine, metal, latex, egg whites, antibiotics, pain medication, anesthetics, tape, etc.)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reviewed by Dr \_\_\_\_\_

