FOR OFFICE USE:
Established Pt. DLS: _________________
Updated All Paperwork

The Foot and Ankle Center

PATIENT INFORMATION

DATE: ____________________ **DATE OF BIRTH: _______/_______/_______ AGE: _____________ SEX: M F**

PATIENT NAME: ____
FIRST MI LAST

ADDRESS: ____

CITY: ____________________________________ STATE: _______________________ ZIP: ______________________

HOME PHONE: ____________________________________ CELL PHONE: _______________________________________

WORK PHONE: ____________________________________ E-MAIL: ____

PATIENT EMPLOYER/ SCHOOL: ____

EMPLOYER /SCHOOL ADDRESS: ____

OCCUPATION: ____

CHIEF COMPLAINT: ____

____ WHICH FOOT: RIGHT LEFT BOTH

FAMILY PHYSICIAN NAME/ADDRESS: ____

DATE OF LAST VISIT _______/_______/_______

PHARMACY NAME: _____________________________________ PHARMACY PHONE: ____________________________

EMERGENCY CONTACT

NAME: ___________________________ PHONE: ___________________________ RELATIONSHIP: __________________

NAME: ___________________________ PHONE: ___________________________ RELATIONSHIP: __________________

IS THERE A PERSONAL OR FAMILY HISTORY OF DIABETES? YES NO

IF YES, PLEASE LIST: ____

IS THERE A HISTORY OF TOBACCO USE? YES NO YEARS SMOKED_______ IF QUIT WHEN______________

DO YOU HAVE A LIVING WILL OR ADVANCED DIRECTIVE? YES NO

IF YES, NAME OF SURROGATE DECISION MAKER: _________________________________

WHO MAY WE THANK FOR REFERRING YOU? : ____

PATIENT NAME____

MEDICAL HISTORY

ANEMIA	Y	N	EPILEPSY	Y	N	PHLEBITIS	Y	N
ANGINA	Y	N	FOOT OR LEG CRAMPS	Y	N	PSYCHIATRIC CARE	Y	N
ARTHRITIS	Y	N	GOUT	Y	N	RADIATION TREATMENT	Y	N
ARTIFICIAL HEART VALVES OR JOINTS	Y	N	HEART DISEASE	Y	N	RASH	Y	N
ASTHMA	Y	N	HEMOPHILIA	Y	N	RESPIRATORY DISEASE	Y	N
BACK PROBLEMS	Y	N	HEPATITIS	Y	N	SHORTNESS OF BREATH	Y	N
BLEEDING DISORDERS	Y	N	HIGH BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	JAUNDICE	Y	N	SWELLING IN ANKLES/FEET	Y	N
CHEMICAL DEPENDENCY	Y	N	KIDNEY PROBLEMS	Y	N	TIRED FEET	Y	N
CIRCULATORY PROBLEMS	Y	N	LIVER DISEASE	Y	N	TUBERCULOSIS	Y	N
DIABETES	Y	N	LOW BLOOD PRESSURE	Y	N	ULCERS	Y	N
LAST GLUCOSE READING: ____________			NEUROPATHY	Y	N	VARICOSE VEINS	Y	N

HEMOGLOBIN A1C: ____________

LAST BLOOD PRESSURE: _______________

HT: _______ WEIGHT: _______ SHOE SIZE: _______

HAVE YOU HAD THE FLU VACCINE THIS YEAR? Y N

HAVE YOU EVER HAD THE PNEUMONIA VACCINE? Y N

SURGERIES YOU HAVE HAD: ____

HOSPITALIZATIONS OTHER THAN FOR THE SURGERIES LISTED: ______________________________________

____

ARE YOU CURRENTLY, OR HAVE YOU BEEN, UNDER ANY OTHER DOCTOR'S CARE FOR ANY REASON OVER THE PAST 2 YEARS? Y N

IF YES, PLEASE EXPLAIN: ____

MEDICATIONS

(INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS AND VITAMINS) ______________________________

____

ALLERGIES

Y N (IF YES, PLEASE LIST) ____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

____ ______________________

SIGNATURE of Patient, Parent, Guardian or Personal Representative **Date**

____ ______________________

Please PRINT name of Patient, Guardian or Personal Representative **Relationship to Patient**