REVSION: 11/2016

"X" Location:

MEDICAL INFORMATION

Associated Foot Surgeons

❑ Belleville ❑ O'Fallon ❑ Columbia ❑ Maryville ❑Chester ❑ Sparta ❑ Staunton 20_____

Name:	Date of Birth:

Describe your foot problem: ❑ Right ❑ Left ❑ Both Feet	Shoe Size:	Weight:	Height:

How long has it been troubling you? _____Days _____Weeks _____Months _____Years	Was this from an injury? ❑ Yes ❑ No If so, when? Where?

Is this a Workman's Compensation claim? ❑ Yes ❑ No Contact Person:
Phone #:
Claim #:

Any past problems with your feet and/or ankles?

Any past surgical procedures on your feet and/or ankles?

Allergies or sensitive to any of the following: ❑ See provided list
(Antibiotics, Medicines, Tape, Other) ❑ **No Known Allergies**

Do you have or are you being treated for Diabetes? ❑ Yes ❑ No If Yes, how long? _____

Medications you are taking: ❑See patient's list ❑Not taking any medications currently

Have you had any problems taking aspirin or ibuprofen? *(Advil, Motrin, etc.)* ❑ Yes ❑ No

Any problems with local anesthetics *(Novocaine, Lidocaine)*
❑ Yes ❑ No *(If yes, describe)*

Have you had any surgeries? (List to include year)

FAMILY HISTORY:		**Their** History of:
Mother	❑ Living ❑ Deceased, if so Cause of death:	❑ Arthritis ❑Cancer ❑Circulation problems to feet ❑ Diabetes ❑ Heart Disease ❑ High BP ❑ Stroke ❑ Neurological disorders ❑ Foot Problems
Father	❑ Living ❑ Deceased, if so Cause of death:	❑ Arthritis ❑Cancer ❑Circulation problems to feet ❑ Diabetes ❑ Heart Disease ❑ High BP ❑ Stroke ❑ Neurological disorders ❑ Foot Problems
Brother(s)	#____ Living #____ Deceased, if so Cause of death:	❑ Arthritis ❑Cancer ❑Circulation problems to feet ❑ Diabetes ❑ Heart Disease ❑ High BP ❑ Stroke ❑ Neurological disorders ❑ Foot Problems
Sister(s)	#____Living #____ Deceased, if so Cause of death:	❑ Arthritis ❑Cancer ❑Circulation problems to feet ❑ Diabetes ❑ Heart Disease ❑ High BP ❑ Stroke ❑ Neurological disorders ❑ Foot Problems

OVER

CHECK ANY OF THE FOLLOWING YOU HAVE , OR HAVE HAD PROBLEMS WITH:

X	← X HERE FOR THIS COLUMN	X	← X HERE FOR THIS COLUMN	X	← X HERE FOR THIS COLUMN	X	← X HERE FOR THIS COLUMN
	ANEMIA		**ANGINA**		**ANXIETY**		**ARTHRITIS**
	ASTHMA		**BACK PROBLEMS**		**CANCER**		Cancer**: SKIN**
	Circulation: **EMBOLISM**		*Circulation:* **HEART DISEASE**		*Circulation:* **PERIPHERAL VASCULAR DISEASE (PVD)**		*Circulation:* **PHLEBITIS**
	Circulation: **VARICOSE VEINS**		**CORONARY ARTERY DISEASE**		**CRAMPS, FOOT OR LEG** *(TEXT)*		**DERMATITIS**
	DIABETES		*Digestive:* **GASTRIC ULCERS**		*Digestive:* **GI BLEED**		*Digestive:* **LIVER DISEASE**
	Ears: **HEARING PROBLEM**		*Endocrine:* **DIABETIC FOOT PROBLEMS**		*Endocrine:* **DIABETIC USING INSULIN**		*Endocrine:* **THYROID DISORDER**
	EPILEPSY		*Eyes:* **EYE DISORDER**		*Genitourinary:* **KIDNEY DISEASE**		**GERD (GASTRIC REFLUX)**
	GOUT		**HEADACHE**		**HEART ATTACK (MI)**		*Hematologic:* **BLOOD DISORDER**
	HEPATITIS		**HIGH BLOOD PRESSURE**		**SWELLING TO ANKLES /FEET** *(TEXT)*		*Infectious:* **RHEUMATIC FEVER**
	MIGRAINE		**MITRAL VALVE PROLAPSE** *(TEXT)*		**MRSA Infections** *(TEXT)*		*Musculoskeletal:* **ARTIFICAL JOINT(S):**
	Musculoskeletal: **KNEE PROBLEMS**		**NEUROPATHY** *(TEXT)*		*Other:* **ANESTHESIA PROBLEMS**		*Other*: **RADIATION TREATMENT**
	Other: **STEROID TREATMENT**		**PNEUMONIA**		**POST-SURGICAL BLOOD CLOTS** *(TEXT)*		*Psychologic:* **PSYCHIATRIC DISORDER**
	RENAL STONES (KIDNEY)		*Respiratory:* **CHRONIC LUNG DISEASE**		*Respiratory:* **PULMONARY EMBOLUS**		*Respiratory:* **RESPIRATORY DISEASE**
	RESTLESS LEG SYNDROME *(TEXT)*		*Rheumatologic:* **RHEUMATOID ARTHRITIS**		**STROKE**		**HIV/AIDS**
	TUBERCULOSIS (TB)		**Other chronic problems not listed:**				

Do you smoke or use tobacco products? ❑ Yes ❑ No | If yes, how much per day?

If no, have you smoked or use tobacco products in the past? ❑ Yes ❑ No | Number of years? | Year stopped?

Do you drink alcohol or beer? ❑ Yes ❑ No | If yes, how much? ❑ 1-2 per week ❑ 1-2 per day ❑ More than 2 daily

Present Employment: ❑ Sitting ❑ Standing ❑ Standing & Walking How many hours per day _____

❑ **Retired** ❑Present or ❑Previous occupation:_____ Year(s): _____

Recreational activities:

To whom can we thank for your referral? ❑ Primary Care Doctor ❑Friend:_____

❑Relative: ❑ Other Doctor: _____ ❑ Internet ❑ Phone Book

Your Primary Pharmacy

❑CVS ❑Medco ❑Schuncks ❑Target ❑Walgreens ❑Wal-Mart **Phone:**

Other:

Street:

City or Zip

Form Completed by: | Relationship: ❑ Self ❑ Father ❑ Mother ❑ Legal Guardian ❑ Other:

Signature: | Date: