Family Foot and Ankle Centers

Patient's Name _____ **Date of Birth** _____

Please Answer All of the Questions: **Shoe size:** _____ **Shoe type:** _____

Chief Complaint: _____

How is your general health? _ Excellent Good Poor **Height** _____ **Weight** _____

Please check all that apply:

_ Anxiety / Depression
_ Cholesterol
_ Diabetes
_ Stroke
_ Leg Cramps
_ Epilepsy
_ Tumors
_ Bleeding Problems
_ Glaucoma
_ HIV
_ Asthma
_ High Blood Pressure
_ Tuberculosis
_ Kidney Trouble
_ Arthritis
_ Varicose Veins
_ Cancer
_ Blood Clots
_ Fibromyalgia
_ Thyroid
_ Gout
_ Stomach Ulcer
_ Polio
_ Heart Trouble
_ Anemia
_ Circulation
_ Fainting Spells

Other Previous Illnesses: _____

Previous Operations or Hospitalizations: _____

_____

Previous Injuries: _____

Family Medical Problems: (please list problems by family member i.e. mother, father, sister, brother, etc.)

Member: _____ Problem(s) _____

Member: _____ Problem(s) _____

Member: _____ Problem(s) _____

What Medications are you taking? (Please include prescription, over-the-counter, and herbal supplements)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any allergies? _ YES or NO *If Yes Please select from the following:*

_ Aspirin
_ Novocaine
_ Codeine
_ Demerol
_ Latex
___ Mercurials
___ Merthiolate
___ Iodine
_ Adhesive
Other: _____
_ Nylon/Plastic
_ Antihistamines
_ Penicillin
_ Sulfa

Reaction: _____

Smoking Status: _ Current Every Day Smoker _ Current Some Day Smoker
_ Former Smoker _ Never Smoker

Are you a Tobacco User _ Yes _ No