

# Family Foot and Ankle Centers

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please Answer All of the Questions: Shoe size: \_\_\_\_\_ Shoe type: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Ethnicity: \_\_\_ Hispanic or Latino \_\_\_ Not Hispanic or Latino

Race: \_\_\_ American Indian or Alaskan Native \_\_\_ Asian \_\_\_ Black or African American  
\_\_\_ Native Hawaiian or other Pacific Islander \_\_\_ White

How is your general health? \_\_\_ Excellent \_\_\_ Good \_\_\_ Poor

Primary Care or Referring Physician's name & address: \_\_\_\_\_

**Please check all that apply:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Gout            |
| <input type="checkbox"/> Stroke            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcer   |
| <input type="checkbox"/> Leg Cramps        | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Polio           |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Kidney Trouble      | <input type="checkbox"/> Heart Trouble   |
| <input type="checkbox"/> Tumors            | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Anemia          |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Varicose Veins      | <input type="checkbox"/> Circulation     |
| <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Fainting Spells |

Other Previous Illnesses: \_\_\_\_\_

Previous Operations or Hospitalizations: \_\_\_\_\_

Previous Injuries: \_\_\_\_\_

Family Medical Problems: \_\_\_\_\_

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:*

- |                                    |                                      |   |
|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Aspirin   | <input type="checkbox"/> Mercurials  | <input type="checkbox"/> Nylon/Plastic  |
| <input type="checkbox"/> Novocaine | <input type="checkbox"/> Merthiolate | <input type="checkbox"/> Antihistamines |
| <input type="checkbox"/> Codeine   | <input type="checkbox"/> Iodine      | <input type="checkbox"/> Penicillin     |
| <input type="checkbox"/> Demerol   | <input type="checkbox"/> Adhesive    | <input type="checkbox"/> Sulfa          |
| <input type="checkbox"/> Latex     | Other: _____                         |   |

Reaction: \_\_\_\_\_

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