

WELCOME TO OUR OFFICE

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**SURGICAL & ORTHOPEDIC
MANAGEMENT OF FOOT DISORDERS**

Name _____ Soc. Sec. No. _____

Date of Birth _____ Age _____ Male Female Marital Status _____

Home Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Email Address _____

Name of Spouse or Parent _____

Next of Kin/Emergency Contact (name and phone) _____



How were you referred to the office? Patient _____ Doctor's Office _____ Other _____

Family Doctor _____ Date of last visit _____

Other (if checked above) _____

Employer _____ Employer Phone Number _____

Employer Address _____ Position _____

Is this condition work related? Yes No Did this injury occur at school? Yes No

Is this condition auto related? Yes No Injury or Trauma? Yes No

INSURANCE INFORMATION

Type of Insurance _____ Policyholder _____

Policyholder Birth date _____ Policyholder Soc. Sec. No. _____

Policyholder Address _____

Relationship to Patient _____ Policyholder Employer _____

Employer Address _____

Employer Contact & Phone Number _____

Name: _____ Patient's Age: _____ Date: _____

CHIEF COMPLAINT - What brought you to the doctor today?

Is this condition work related? Yes No Did this injury occur at school? Yes No

Is this condition auto related? Yes No Injury or Trauma? Yes No

Date of Injury: _____

Type of Problem

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Corns, Callous, Nails | <input type="checkbox"/> Fracture/Sprains | <input type="checkbox"/> Warts, Tumors | <input type="checkbox"/> Bunions, Hammertoes |
| <input type="checkbox"/> Diabetic Foot Care | <input type="checkbox"/> Ingrown Nail | <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Neuroma or Nerve Pain |
| <input type="checkbox"/> Other | <input type="checkbox"/> Injury | <input type="checkbox"/> Numbness | |

When did the pain start? _____ Describe Pain. _____

Where does it hurt? _____ When does it hurt? _____

Previous episodes? _____ Previous treatment and response? _____

Past Medical History Do you have a history of any of the following?

- | | | | | |
|--|--|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Heart/Circulation Trouble | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatism/Arthritis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Mitral Valve Prolapse | | <input type="checkbox"/> Osteoporosis | |

Past Surgical History Have you had any surgery before? Yes No

If yes, please list procedure and date _____

Allergies Do you have any allergies to medications? Yes No

- | | | | | |
|--|--------------------------------------|---------------------------------|------------------------------------|--|
| <input type="checkbox"/> NSAIDS | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Codeine | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Novacaine | <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Iodine | <input type="checkbox"/> Adhesives | <input type="checkbox"/> Metal or Nickel |
| <input type="checkbox"/> Environmental | Other: _____ | Type of reaction _____ | | |

Are you allergic to latex products? Yes No

Medications List all prescription medications you take; include dosage and frequency. Insulin, inhaler, and patches should be included here.

List all non-prescription medications you take routinely _____

Name: _____

Date: _____

Social History

Marital Status _____ Children _____ Patient's Age _____

Do you or have you ever smoked? Yes No How Much _____

Do you drink alcohol? Yes No How Much _____

What type of job do you have? _____

Family History List illnesses or health issues.

In whom:

Father _____ Mother _____

Siblings _____ Children _____

Review of Systems Please check if you have any of the following

CONSTITUTIONAL

- Fever
- Weight loss
- Lethargy

GENITOURINARY

- Frequency
- Blood in urine
- Abnormal urine color
- Painful urination
- Awaken to urinate
- Unable to fully empty bladder
- Incontinence

NEUROLOGICAL

- Headache
- Fainting
- Dizziness
- Memory loss
- Numbness

ENDOCRINE

- Night sweats
- Thyroid disease
- Diabetes
- Heat/Cold intolerance
- Frequent urination
- Frequent thirst

CARDIOVASCULAR

- Shortness of breath
- Chest pain (angina)
- Heart palpitations
- Heart attack
- Stroke
- Cold extremities
- Hypertension
- CHF

MUSCULOSKELETAL

- Pain -
 - Muscles Neck
 - Back Hips
 - Knees Ankles Feet
- Limited range of motion
- Limited strength
- Arthritis
- Gout

INTEGUMENTARY

- Rash
- Itching
- Dry Skin
- Toenail/Fingernail changes

GASTROINTESTINAL

- Pain
- Diarrhea
- Constipation
- Blood in stool/dark stool
- Mucus in stool
- Nausea
- Vomiting
- Vomit blood
- Heartburn
- Change in stool
- Food intolerance
- Loss of appetite
- Yellow eyes or skin

HEMATOLOGIC/LYMPHATIC

- Easy bruising
- Anemia
- Blood abnormalities
- Blood thinners
- Lymph node enlargement

Unmarked box indicates that the patient denies this problem.

Physician Review _____ **Date** _____