

**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?

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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? \_\_\_\_\_

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**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 \_\_\_\_\_

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**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.

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List all non-prescription medications you take routinely \_\_\_\_\_

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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** \_\_\_\_\_