

Name: _____ Date: _____ AGE: _____

Referring Physician: _____ Regular Physician: _____

Approximate date of the last visit with your regular physician: _____

**The following information is important for your maximum safety and optimum care.
The office will hold this information in utmost confidence.**

I. Present Illness

My Primary foot / ankle problem today is: _____

II. Medical History

Are you being treated for or have you ever been treated for any of the following:

- | | | | |
|---------------------|--|--------------------|--|
| HIGH BLOOD PRESSURE | <input type="checkbox"/> YES <input type="checkbox"/> NO | DIABETES | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HIGH CHOLESTEROL | <input type="checkbox"/> YES <input type="checkbox"/> NO | ARTHRITIS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ANEMIA | <input type="checkbox"/> YES <input type="checkbox"/> NO | KIDNEY TROUBLE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HEART DISEASE | <input type="checkbox"/> YES <input type="checkbox"/> NO | STOMACH ULCERS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HEART ATTACK | <input type="checkbox"/> YES <input type="checkbox"/> NO | BLEEDING PROBLEMS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| MITRAL VALVE | <input type="checkbox"/> YES <input type="checkbox"/> NO | BLOOD CLOTS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| STROKE | <input type="checkbox"/> YES <input type="checkbox"/> NO | EPILEPSY / SEISURE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| SKIN RASH / HIVES | <input type="checkbox"/> YES <input type="checkbox"/> NO | THYROID DISEASE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| TUBERCULOSIS | <input type="checkbox"/> YES <input type="checkbox"/> NO | IRRITABLE BOWEL | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CANCER / TUMOR | <input type="checkbox"/> YES <input type="checkbox"/> NO | ACID REFLUX | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ASTHMA | <input type="checkbox"/> YES <input type="checkbox"/> NO | OTHER _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please explain any YES answer(s) below:

Medical Condition	Diagnosis / Treatment	Hospital Name	Doctor & Address

Have you ever tested positive for the following:

- | | | |
|---------------------|--|---------------------------|
| HIV / AIDS | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, which type? _____ |
| Hepatitis | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Sickle Cell Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | |

Are you pregnant? YES NO If Yes, _____ weeks
If No, Date of last menstrual cycle: _____ / _____ / _____

III. Medications

Please list any medications you are currently taking and their dosage:
Attention: PLEASE NOTE IF YOU ARE ON COUMADIN, ASPIRIN, PLAVIX, OR PREDNISONE

Medication	Daily Dosage	Medication	Daily Dosage

IV. Allergies

Are you allergic or have you had an adverse reaction to any of the following:

- PENICILLIAN YES NO OTHER ANTIBIOICS YES NO
- LOCAL ANESTHESIA YES NO GENERAL ANESTHESIA YES NO
- CODEINE YES NO ASPIRIN YES NO
- SULFA DRUGS YES NO TAPE OR BAND-AIDS YES NO
- IODINE YES NO LATEX YES NO
- SEDATIVES YES NO SHELLFISH YES NO
- OTHER _____ YES NO OTHER _____ YES NO

If Yes, What is the reaction experienced? _____

V. Surgery

Please list all surgeries that you have had and the date performed

Surgery	Date	Surgery	Date
1.		3.	
2.		4.	

Did you experience any major complications? _____

Do you form keloids or excessive scars? YES NO

VI. Social History

Occupation: _____ How long are you on your feet during the day? _____

Do you smoke? YES NO If Yes, how many per day? _____ How many years? _____

Do you drink? YES NO If Yes, how frequent? _____ How much? _____

VII. Family History

Is there a family history of significant medical conditions? Please include bleeding problems & blood clots.

Medical Condition	Relation

VIII. Review of System

- HEAD: dizziness blurred / loss of vision hearing loss
- HEART: leg swelling circulation problems chest pain with exertion
- LUNG: sleep apnea shortness of breath history of bronchitis
- GI: nausea vomiting difficulty swallowing
- GU: blood in urine constipation difficulty urinating
- SKIN: recent rash skin lesions growing / changing history of wounds
- HEME: raynauds varicose veins bleeding problems
- NEURO: memory loss numbness / weakness
- PSYCHE: depression anxiety attacks

I hereby authorize the physicians and their assistants of the Ankle & Foot Centers of Georgia to administer treatment as deemed necessary.

Signature of Patient or Responsible Party

Date