Ankle & Foot Associates

PODIATRY MEDICAL FORM

MEDICAL. 01-21

Orange Park 981 Kingsley Ave (904) 269-9595 | **Jacksonville Beach** 2710 3rd St South (904) 269-9595

Shoe Size _____

☐ Narrow ☐ Wide
☐ Medium

Height _____

Weight _____

Is there a possibility of being pregnant? ☐ Yes ☐ No

Do you use tobacco?

☐ No ☐ Cigar ☐ Vape
☐ Recently quit ☐ Cigarette ☐ Other

For how many years? _____ How many per day? _____

Do you use alcohol?

☐ Yes ☐ No

If yes, frequency?

_____

Do you use illegal drugs?

☐ Yes ☐ No

List all surgeries in the past 10 years with approximate dates *(fill in below)* or ☐ None

_____ _____
_____ _____
_____ _____

List all medications along with dosage. If more, provide a separate list *(signed and dated)* or ☐ None

_____ _____
_____ _____

List all vitamins and supplements as well as dosage or ☐ None

_____ _____

Drug & Food Allergies (*check all that apply)*

☐ None ☐ Codeine ☐ Metal ☐ Demerol ☐ Cipro ☐ Environmental ☐ Other _____
☐ Sulfa ☐ Aspirin ☐ Penicillin ☐ Iodine ☐ Latex ☐ Food _____

Circle One Below *(Y = You M = Mother F = Father)*

Y M F AIDS/HIV
Y M F Anemia
Y M F Asthma
Y M F High / Low Blood pressure *(circle one)*
Y M F Blood clots or bleeding disorder
Y M F Cancer
Y M F Chest pain
Y M F Circulatory problems
Y M F Diabetes
Y M F Epilepsy
Y M F Eye problems
Y M F Fainting
Y M F GERD
Y M F Hearing loss
Y M F Headaches
Y M F Heart disease/attack
Y M F Hepatitis (chronic)
Y M F High cholesterol
Y M F Jaundice
Y M F Mental health condition
Y M F Obesity or overweight
Y M F Osteoporosis
Y M F Phlebitis
Y M F Stroke
Y M F Tuberculosis
Y M F Ulcers
Y M F Varicose veins
Y M F Arthritis
Y M F Back/spine pain
Y M F Foot/ankle swelling
Y M F Joint/muscle pain
Y M F Joint/muscle stiffness
Y M F Gout

For Diabetics

Name of physician treating you

_____

Type:
☐ 1
☐ 2

Circle all you are experiencing:

☐ Sweating ☐ Frequent urination
☐ Thirst ☐ Heat or cold intolerance
☐ Appetite change ☐ Other _____

COVID-19

Recently tested ☐ Yes ☐ No
Positive diagnosis ☐ Yes* ☐ No
Date of last negative test _____

**Please notify staff if yes*

Have you had a pneumonia vaccine in the past *(not influenza)*?

☐ No ☐ Can't recall ☐ Yes, approx. date _____

I certify the information given above is true and correct to the best of my knowledge.

PRINTED PATIENT NAME : | **INITIAL:** | **DATE:**