ANKLE AND FOOT ASSOCIATES

HEIGHT WEIGHT SHOE SIZE narrow medium wide

**SURGERIES:** In the past **10 years** with **appx. dates** ◯ **none**

1 2 3

4 5 6

Is there a possibility of being pregnant? NO YES

Do you use tobacco? NO YES cigar cigarette _________________other

How many years?________ How many per day?______Have you recently quit? ______

Do you use alcohol? NO YES Frequency_____________ Do you use illegal drugs? NO YES

**MEDICATIONS:** LIST ALL **MEDS & DOSAGE.** IF MORE, PROVIDE A LIST. **Sign and Date your list.** ◯ **none**

1 2 3

4 5 6

List all vitamins & supplements as well as dosage ◯ none ______________________________________________________

**DRUG ALLERGIES:** Check all that are applicable.

| | | | | |
|---|---|---|---|---|
| ◯ Sulfa | ◯ Penicillin | ◯ Aspirin | ◯ Codeine | ◯ Demerol |
| ◯ Iodine | ◯ Cipro | ◯ Other________________________ | ◯ **none known** | |

Food Environmental Allergies ________________________________ ◯ **latex** ◯ none

Have you had a pneumonia vaccine in the past (**NOT FLU**)? ___yes appx. date ______________________, ___no, ___can't recall

**CIRCLE Y=YOU M=MOTHER F=FATHER**

| | | | |
|---|---|---|---|
| Y M F AIDS/HIV | Y M F Fainting | Y M F Phlebitis | Y M F Arthritis |
| Y M F Anemia | Y M F GERD | Y M F Stroke | Y M F Back/spine pain |
| Y M F Asthma | Y M F Hearing Loss | Y M F Tuberculosis | |
| Y M F B/P high low (circle) | Y M F Headaches | Y M F Ulcers | Y M F Foot/ankle swelling |
| Y M F Blood clots Bleeding/disorder | Y M F Heart (disease/attack) | Y M F Varicose veins | |
| | Y M F Hepatitis chronic | Y M F All other:__________ | Y M F Joint/muscle pain |
| Y M F Cancer:__________ | Y M F High Cholesterol | Y M F | |
| Y M F Chest pain | Y M F Jaundice | Y M F | Y M F Joint/muscle stiffness |
| Y M F Circulatory problem | Y M F Mental health cond. | Y M F | |
| Y M F Epilepsy | Y M F Obesity/overweight | | Y M F Gout |
| Y M F Eye Problems | Y M F Osteoporosis | Y M F **DIABETIC** | |

**IF YOU ARE DIABETIC THE NAME OF PHYSICIAN TREATING YOUR DIABETES:**________________________________

**TYPE 1 2 CIRCLE**

Circle all **YOU** experience: Sweating, Thirst, Frequent urination, Appetite change, Heat or cold intolerance

other ____________________________________________________________.

Patient name please print______________________________________________________________

I certify the information given above is true & correct to the best of my knowledge . Initial ____________date______

Medical 6-2019