Please Complete

Medical History

What is your foot and/or ankle complaint today?____

____

When did this start?_______ Days _______ Weeks _______Months _______ Years

Is the problem getting worse or unchanged?____

Does it affect your walking? Y N

Pain level: 1 being minor, 10 being severe Does it affect your ability to exercise? Y N

1 2 3 4 5 6 7 8 9 10

Is this a result of trauma? Y N

If so, What is the date of your injury?______________________

How would you describe your pain? (Circle all that apply)

Generalized Localized Throbbing Radiating Burning Numbness Dull Ache Sharpe Ache

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Have you ever had any of the following? (Circle all that apply)

Anemia Arthritis Asthma Afib Anxiety Disorder Blood Disorders

Bleeding Abnormality Cancer Circulation Problems COPD Diabetes Epilepsy/Seizure

Heart Disease Heart Murmur High Blood Pressure Hepatitis or Liver Disease HIV/AIDS

Gout High Cholesterol Kidney Disease MRSA Neuropathy Sickle Cell Skin Rash/Hives

Skin Ulcer Stomach Ulcers Stroke Thyroid Disease Tuberculosis Varicose Veins

Other:____

Surgeries

Have you ever had any surgery? ***(List surgeries old or new, we do not need the dates if you don't remember.)***	

Social History

Do you Smoke? YES NO	Previous Smoker?
If applies, How many packs a day?	Do you drink? (Circle Answer) NO Yes:5/7 Days weekly Yes:Socially Yes:Rarely

Are you pregnant? YES NO *Please note we may take x-rays during your visit, so please inform us if there is a chance you may be pregnant. Medications we may prescribe (I.e antibiotics) could change the effectiveness of birth control medications.