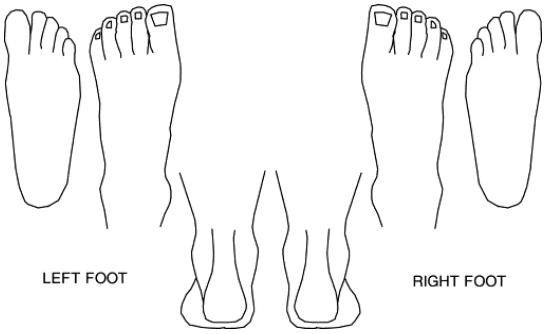
Capital Foot & Ankle
Surgeons of Austin

Name (Last, First, M.I.):_____ **Sex:** ☐M ☐F ☐Other **DOB:**_____/_____/_____
Reason for visit: _____ **Date of injury:**_____/_____/_____
Please mark the location of your foot/ankle pain: **Shoe Size:**_____



REVIEW OF SYSTEMS	
Please check if you have recently been experiencing any of the following:	
General	☐Fatigue ☐Fever/chills ☐Recent weight change ☐No symptoms
Skin	☐Rash ☐Itching ☐Lesions/sores/lumps ☐No symptoms
Eyes	☐Blurred vision ☐Blindness ☐Floaters ☐No symptoms
Ears	☐Deaf ☐Decreased hearing ☐Dizziness ☐No symptoms
Nose	☐Loss of smell ☐Nose bleeds ☐Sinus problems ☐No symptoms
Respiratory	☐Shortness of breath ☐Wheezing ☐Coughing ☐No symptoms
Cardiovascular	☐Chest pain ☐Swelling ankle/feet ☐High blood pressure ☐No symptoms
Neurologic	☐Seizures ☐Numbness ☐Headaches ☐No symptoms
Gastrointestinal	☐Nausea ☐Vomiting ☐Abdominal pain ☐No symptoms
Genitourinary	☐Frequent urination ☐Painful urination ☐Incontinence ☐No symptoms
Hematologic	☐Bleeding ☐Excessive bruising ☐Use of blood thinners ☐No symptoms
Musculoskeletal	☐Limitation in motion ☐Weakness ☐Stiffness ☐No symptoms
Vascular	☐Calf pain ☐Leg cramp ☐Resting pain ☐No symptoms
Endocrine	☐Excessive thirst ☐Excessive urination ☐Thyroid problems ☐No symptoms
Psych	☐Anxiety ☐Depression ☐Insomnia ☐No symptoms

PERSONAL HEALTH HISTORY	
List any medical problems that other doctors have diagnosed you with:	
☐Cancer	Type: Location:
☐OB/GYN	
☐Skin	☐Scleroderma ☐Steven Johnson Syndrome
☐Head, ears, eyes	☐Cataracts ☐Macular Degeneration ☐Retinal Detachment ☐Blind ☐Deaf
☐Respiratory	☐Asthma ☐COPD ☐Pulmonary Embolism ☐Sleep Apnea
☐Cardiac Problems	☐Congestive Heart Failure ☐Coronary Artery Disease ☐Blood Clot ☐Murmur ☐High Cholesterol ☐Hypertension ☐Mitral Valve Prolapse ☐Stroke ☐Heart Attack (when?)
☐Gastrointestinal	☐Gastro-esophageal Reflux ☐Hepatitis ☐IBS ☐Peptic Ulcer
☐Urinary	☐Renal Failure ☐Dialysis (what days?)
☐Musculoskeletal	☐Back Pain ☐Osteoarthritis/Arthritis ☐Osteoporosis ☐Raynaud's Syndrome
☐Neurologic	☐Alzheimer's ☐Multiple Sclerosis ☐Neuropathy ☐Seizures ☐Parkinson's Disease
☐Psychiatric	☐Alcoholism ☐Anxiety ☐Depression ☐Attention Deficit Disorder ☐Drug Abuse
☐Hematologic	☐Anemia ☐Sickle Cell
☐Endocrine	☐Diabetes ☐Hyperthyroidism ☐Hypothyroidism

☐Allergy/Immunology	
☐Infectious disease	☐AIDS ☐HIV ☐Osteomyelitis
☐Rheumatology	☐Ankylosing Spondylitis ☐Fibromyalgia ☐Gout ☐Reiter's Syndrome ☐Rheumatoid Arthritis
☐Trauma	☐Motor Vehicle Accident ☐Fractures/broken bones (location?)
Please add or explain any other medical condition	

SURGERIES/HOSPITALIZATIONS	
YEAR	REASON

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
NAME OF MEDICINE	STRENGTH	FREQUENCY TAKEN

ALLERGIES	
Do you have any allergies to medication? ☐Yes (list below ☐No (skip to the next section)	
NAME OF MEDICINE	LIST REACTION SYMPTOMS

SOCIAL	
Marital status	☐Single ☐Married ☐Domestic Partner ☐Divorced ☐Widow
Exercise	☐Sedentary (no exercise) ☐Exercise (i.e. climb stairs, walk 3 blocks, golf) Activity? _____ How often?
Alcohol	Do you drink alcohol? ☐Yes ☐No If yes, how many times per week?
Tobacco	Do you use tobacco products? ☐Yes ☐No Cigarettes - pks/day Other:
Drugs	Do you currently use recreational/street drugs? ☐Yes ☐No

FAMILY HEALTH HISTORY			
Paternal	☐Alive ☐Deceased	Cause of death?	Age:
Maternal	☐Alive ☐Deceased	Cause of death?	Age:
# of sisters:	☐Alive ☐Deceased	Cause of death?	Age:
# of brothers:	☐Alive ☐Deceased	Cause of death?	Age:

Patient/Guardian Signature: _____ Date: _____/_____/_____