

FOOT AND ANKLE PHYSICIANS, P.A.

CONFIDENTIAL PATIENT INFORMATION SHEET

PATIENT NAME: _____

PRIMARY CARE DOCTOR: _____

PLEASE SPECIFY THE REASON FOR TODAY'S VISIT

LEFT FOOT _____ RIGHT FOOT _____ BOTH _____

WHICH IS THE AFFECTED AREA? ANKLE _____ HEEL _____ NAILS _____ SKIN _____ OTHER: _____

WHAT ARE YOUR SYMPTOMS? _____

WHEN DO YOUR SYMPTOMS MOSTLY OCCUR? _____

DO YOU HAVE OR HAVE YOU BEEN DIAGNOSED WITH:

CHECK ONE:	YES	NO		YES	NO
CONSTITUTIONAL SYMPTOMS: (fever, weakness)	___	___	INTEGUMENTARY: (skin or nail disorders)	___	___
EYE SYMPTOMS (cataracts, glaucoma)	___	___	NEUROLOGICAL (seizure, stroke, numbness)	___	___
EARS, NOSE, MOUTH, THROAT SYMPTOMS	___	___	PSYCHIATRIC (nervousness, depression)	___	___
CARDIOVASCULAR (high blood pressure, heart disease)	___	___	ENDOCRINE (diabetes, thyroid gland disorders)	___	___
RESPIRATORY (breathing disorders)	___	___	HEMATOLOGIC/LYMPHATIC (anemia, bruising)	___	___
GASTROINTESTINAL (stomach ulcer, liver disease, hepatitis)	___	___	ALLERGIC/IMMUNOLOGIC (allergy to medication, food, tape, latex)	___	___
GENITOURINARY (kidney or urinary disorders)	___	___	CANCER	___	___
MUSCULOSKELETAL (joint pain, arthritis, gout, sprains)	___	___	HIV/IMMUNE DISORDERS	___	___

PLEASE FILL IN COMPLETELY:

YOUR APPROXIMATE: HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

LIST ALL MEDICATIONS CURRENTLY TAKING: _____

LIST ALL OPERATIONS YOU HAVE HAD: _____

SMOKE TOBACCO? _____ HOW OFTEN? _____ DRINK ALCOHOL? _____ HOW OFTEN? _____

RECREATIONAL DRUG USAGE? _____ HOW OFTEN? _____

FAMILY MEDICAL HISTORY: _____

I ACKNOWLEDGE THAT THE ABOVE STATEMENTS ARE TRUE. I HEREBY GIVE MY DOCTOR PERMISSION TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE NECESSARY IN DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION.

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