ABILITY FOOT & ANKLE **NAME:** _____

Patient Medical History

DATE OF BIRTH : DAY ☐☐ MONTH ☐☐ YEAR ☐☐☐☐

Past Medical History: have you been treated for, or do you have any of the following (please check all that apply)

__ Kidney Disease / Failure (stage ___ ?)
__ Liver Disease
__ Peripheral Vascular Disease (poor blood flow)
__History of MRSA Infection
__ Mitral Valve issues / Artificial heart Valve
__ Heart Disease / Prior Heart attack
__ Swelling (Edema) to feet / legs
__ Any History of bleeding / blood disorders ?
__ Congestive Heart Failure
__ High Blood pressure
__ Anemia
__ Thyroid problems
__ Hormone issues (Testosterone / Estrogen)
__ GOUT / History of High Uric Acid Levels
__ Eye problems/ Glaucoma / Blindness
__ Osteoporosis
__ Psychiatric Disorder
__ Cancer / Chemotherapy / Radiation
__ GERD / Stomach ulcers

__ Diabetes Mellitus (recall last A1c level? _____)
(how long a diabetic? _____ years)
__ Neuropathy
__ Degenerative disk disease / Sciatica
__ Breathing difficulties / Lung Disease
__ Autoimmune disease (Rheumatoid, Psoriasis, Lupus, IBS)
__ Excessive Scarring / Keloid formation
__ Broken ankle / Broken foot (Left or Right ? When _____)
__ Vitamin D deficiency
__ Foot wounds / ulcers
__ Childhood Foot Problems
__ Neuroma(s) to feet

Are you pregnant / nursing ?
YES ***NO***

Please write any additional conditions you may have not listed:

Past Surgical History (check all that apply)

__ I HAVE NEVER HAD SURGERY
__ History of prior Foot or Ankle surgery ? When ? _____
__ Stent / Angioplasty (heart or legs)
__ Pacemaker
__ Gastric bypass / Gastric sleeve / Bariatric Surgery
__ Cancer treatments (Chemotherapy / Radiation ?)
__ Any metal implants or joint replacements surgery ?
__ Back surgery

Please list any other surgeries in your past, and any complications you had.

Allergies *(Please check all that apply)*

__ *I have NO KNOWN DRUG ALLERGIES*

__ Penicillin
__ Sulfa medications
__ Other antibiotics (list below)

__ Anti-Inflammatories (list below)

__ Iodine / Contrast media
__ Tape / Adhesives
__ Latex products
__ Tylenol (Acetaminophen)
__ Nickel / certain metals
__ Aspirin
__ Pain Medications (list below)

Please note any other allergies not listed:

Height: _____ ***Do you believe you have a***
Weight _____ *Low Arch foot*? **Y N**
Shoe Size _____ *High Arch foot*? **Y N**
Normal Arch foot? **Y N**

PATIENT HISTORY (PAGE 2) **NAME:**_____ DOB: _____

Social History (circle "**Y**" for Yes, "**N**" for No) *(all questions not answered will be assumed "No")*

Did you use tobacco products? **Y N** how many packs per day ? _____ How long have you smoked ? _____

Have you ever used tobacco products? **Y N** (if so, how long? _____ If you quit, what year did this happen ? _____

Do you VAPE or use Nicotine patches or Nicotine gum ? **Y N**

Do you drink alcohol? **Y N** How many drinks per week ___ liquor ? wine ? beer ?
Do you consume "Energy Drinks" regularly? **Y N** If so, how many per day ? ____
How many cups of coffee do you drink per day ? ____ How many soda drinks do you consume per day ? ____

Do you run on a regular basis ? **Y N** If so, about how many miles per week ? _____

Do you work in an environment where you have to stand on hard surfaces for more than 6 hours a day ? **Y N**

Medications (Please list below)
All questions left unmarked will be assumed "No"

__ I am NOT taking any medications at this time
__ I have a list printed that I can give to staff
__ I currently have a Pain Contract with a doctor

__ I give permission to have my list of medications provided by my pharmacy or other medical facility

** If you give permission to have list provided by Pharmacy or other medical facility, then you can leave the list blank

Do you take any IV infusion medications on a regular basis ? YES NO
Are you currently taking a blood thinning medication? YES NO

Please answer the following Questions by circling "Y" for Yes, or "N" for No

- Have any other physician(s) treated your foot or ankle problem in the past? **Y N**
- Are your first steps out of bed painful ? **Y N**
- Do you get tingling / numbness to your feet in the evening ? **Y N**
- Does foot pain limit your activities of living or ability to perform your job? **Y N**
- Are you slow to heal after cuts ? **Y N**
- Do you use a treadmill routinely ? **Y N**
- Do you visit a chiropractor routinely? **Y N**
- Do you ever notice pain radiating downward from your back or buttocks? **Y N**
- Do you (or have your ever been) prescribed orthotic inserts for your shoes? **Y N**
- Do you consume any of the following: Fish oil, Gingko Biloba, Ginseng, St. John Wort, Garlic, or Echinacea? **Y N**

All above questions left unanswered will be assumed "No"

FAMILY History

Arthritis _____

Diabetes_____

Cancer _____

Stroke _____

Auto Immune_____

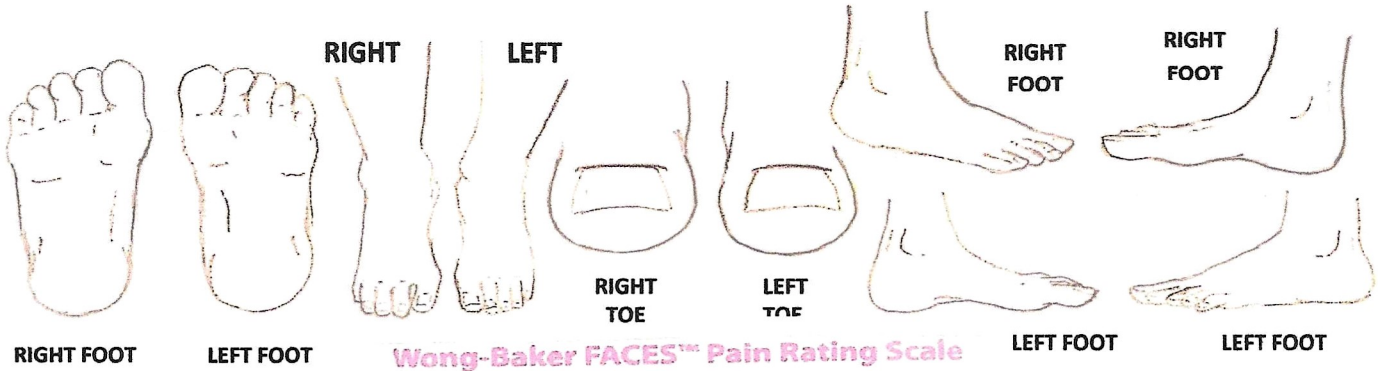
Foot Problems_____

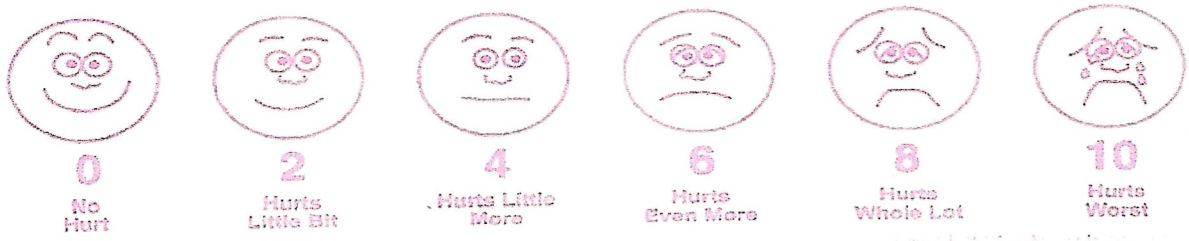
Mother = (M)
Father = (F)
Sister = (S)
Brother=(B)

ABILITY
FOOT & ANKLE
Dr. ANTHONY DeMARIA

NAME: _____ DOB: MONTH ☐☐ DAY ☐☐ YEAR ☐☐☐☐

Pain Identification Sheet





In the above pictures, please mark where your pain is, and indicate it with a number "1"
If you have a secondary problem, indicate the location of that issue with a number "2"

***When** did symptoms begin?* **1 2 3 4 5 6 7 8 9 10 days ago weeks ago months ago years ago.**
(please circle appropriate descriptors)

Please rate the pain on a scale of 0 – 10, with 10 being the worst. Please use the above pain scale for assistance:

Pain level number _____

Is the injury work related ?
☐ YES ☐ NO

Was injury reported? ☐ YES ☐ NO

Date of injury _____

✓ ***PLEASE check all the boxes that best describe the pain***

☐ Sharp ☐ Tingling
☐ Stabbing ☐ Itching
☐ Burning ☐ Binding
☐ Cramping ☐ Dull
☐ Pressure ☐ Pulling
☐ Electric like

Onset of Pain ☐ Slow ☐ Sudden

***Symptoms appear to* (be) :**

☐ **Worsening** ☐ **Improving**
☐ **Worse at Night** ☐ **Worse with cold**
☐ **Worse after rest** ☐ **Go into spasm**
☐ **Worse with activity** ☐ **Come and Go**

Have you tried anything to alleviate the pain?
(enter comments below)

_____

Above information is true to the best of my knowledge: Name: _____ ***Date:*** _____

Name of Person signing on behalf of patient (if unable to sign for themself): _____

Doctor's Signature: _____ ***Date:*** _____