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_____

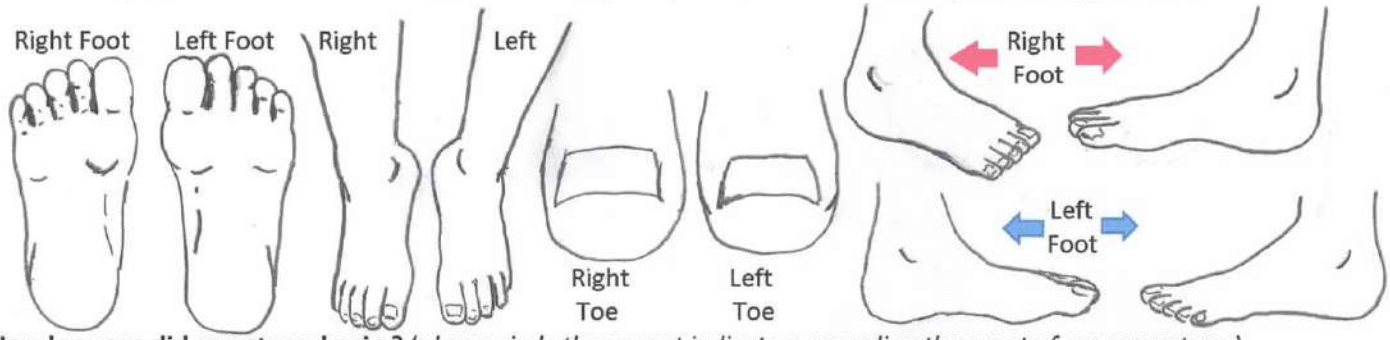
Mother = (M)
Father = (F)
Sister = (S)
Brother=(B)

Foot Problem Identification Sheet

Name: _____ Date of Birth: _____

Reason for office visit : *Please state in a few words the history of your symptom(s).*

Location of pain: Please mark a "**1**" to indicate where your pain is. Mark a "**2**" for any secondary problems.



How long ago did symptoms begin ? (*please circle the correct indicators regarding the onset of your symptoms*)

1 2 3 4 5 6 7 8 9 10 11 12 days weeks months years

Please check below all the boxes that best describe and apply to your symptoms

Pain Description		Pain Onset	Nature of Symptoms	Pain Level
□ Sharp	□ Itching	□ Slow	□ Worsening	Rate pain on scale 1 through 10, # 10 = worst pain possible # 5 = keeps you up at night
□ Stabbing	□ Deep Ache	□ Gradual	□ Worse after resting	
□ Burning	□ Dullness	□ Sudden	□ Worse after getting out of bed	
□ Cramping	□ Throbbing	□ "on and off"	□ Worse with standing / activity	
□ Pressure	□ Pulling	□ after injury	□ Worse with temperature changes	
□ Electricity	□ Gripping	□ after activity	□ Seem to "come and go"	
□ Constricting Tightness	□ Constant		□ worse at night while resting	
	□ Tingling, or Pins & Needles		□ Improving	
			□ Constantly stays the same	**Pain level #**

Do you have any history of back complications, back surgery, pinched nerves or discs, or sciatica ? YES NO

Please circle if your injury work related: YES NO (If "YES", when was the injury reported ?) **DATE:** _____

Have you tried anything to alleviate the pain ? (*please check if any apply*)

□ Visit another doctor	□ Antibiotic(s)	□ Cortisone (pill or injection)
□ Rest	□ Shoe inserts	□ tape strapping
□ Ice	□ stretching	□ Heat
□ Anti-inflammatories	□ Bracing	□ Ultrasound
□ physical therapy	□ Sports cream / balm	□ night splint
□ Foot soaks	□ Different shoes	□ ACE wrap or splint

If you attempted any treatment that is not listed to the left, please indicate it here.

The above information is true to the best of my knowledge: **Name:** _____
(*please provide signature attesting to symptoms*)

Date: _____

Doctor's Signature : _____ Date: _____