Welcome to our office! Please complete the health information below. This information helps us to safely and better care for your needs.	
Your Name: **Age:** **Date of Birth: / /**	

Reason for your visit:	**Primary Care Dr:**
	Referred by:

PAST MEDICAL HISTORY	Yes	No	Other past medical history not otherwise listed:
Anaphylactic reaction			
Arthritis			***MEDICATIONS*** **(including aspirin, birth control pills, over the counter**
Blood clot history			**medications and supplements, both vitamin and herbal)**
Cancer			
Chemical addiction			
Circulation problems			
Depression			
Diabetes			
If YES, average blood sugar:	**A1C:**		
Gout			
Heart Disease			
Heart valve condition/replacement			
HIV/AIDS			
Hyperthyroidism / Hypothyroidism			
Kidney disease / impaired function			
Liver condition			
Osteopenia / Osteoporosis			
Pulmonary embolism			

ALLERGIES *(please check)*	Yes	No	*If yes, reaction*
Tape/Adhesives			
Lidocaine (anesthetics)			
Iodine			
Latex			
NSAIDS/anti-inflammatories			
Penicillin			
Shellfish			
Sulfa Drugs			
X-ray dye			

	Previous foot and ankle surgeries: (note year and any complications)
Current Weight:	
Height:	
Shoe Size:	
Right or Left Handed? ***R / L***	PREFERRED PHARMACY:
Preferred Language:	Other physicians you are actively seeing:

FAMILY HISTORY *(If YES Please Specify which family member)*				SOCIAL HISTORY
Amputation	Y / N	Kidney disease	Y / N	Lives: *Alone / With Others*
Anesthesia problems	Y / N	Lupus/autoimmune disease	Y / N	Occupation :
Arthritis	Y / N	Neurologic disease	Y / N	Hours per shift on feet:
Clotting Abnormalities	Y / N	Peripheral vascular disease	Y / N	Tobacco use: **Y / N** Packs /day:
Diabetes	Y / N	Pulmonary embolism	Y / N	Previous Smoker: Y / N
Heart disease	Y / N			History of recreational drug use: Y / N

REVIEW OF SYSTEMS - *Are you currently experiencing…*

	Y	N		Y	N		Y	N		Y	N
Acid reflux			Chills			Frequent Urination			Shortness of breath		
Back pain			Cold fingers/toes			Itching			Skin rash		
Blackouts			Currently Pregnant			Nausea			Stiffness/pain in AM		
Calf/leg cramps at night			Diarrhea			Nervousness/anxiety			Swelling in legs		
Calf/cramps walking			Dry Throat/Mouth			Numbness in feet			Unstable on feet		
Chest pain			Fluttering heart			Radiating leg pain					

*** Please note: we may need to take x-rays during your visit, so please inform us if there is a chance you may be pregnant. Also, medications we may prescribe (i.e. antibiotics) may reduce the effectiveness of birth control.**

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed this form to the best of my ability.

Signature: **Date:**

Patient or legal guardian: