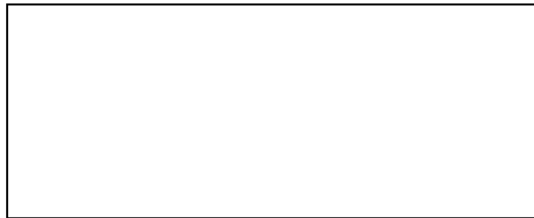

Foot & Ankle Specialists of the Mid-Atlantic

Keeping you on track...For Life!

MEDICAL FORM

First Name ________________________________ **M.I.** ______ **Last Name** ________________________________ **DOB** ___________________

Age _____ **Height** _____ **Weight** _____ **Shoe Size** _____ **Reason for visit**____

How long has this been a problem? ________________________ **When does it occur?** Morning Afternoon Evening Off and On All Day

TREATMENTS: Please list previous treatments (either prescribed or home remedies):

____

____

Is this visit related to an accident/injury? Y N If yes, date of injury_____________________________

LIST CURRENT SPORTS/ACTIVITIES: ____

MEDICATIONS: Please list (or attach a list) of your current medications and their dosages:

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

ALLERGIES: Do you have a history of allergies/skin reaction/sickness following the administration of any of the following:

	Y	N	** If yes, list REACTION		Y	N	** If yes, list REACTION
Adhesive tape	__	__	_________________	**Foods**	__	__	_________________
Anesthesia	__	__	_________________	**Iodine**	__	__	_________________
Aspirin	__	__	_________________	**Latex**	__	__	_________________
Caffeine	__	__	_________________	**Local Anesthetics**	__	__	_________________
Codeine	__	__	_________________	**Penicillin**	__	__	_________________
Cortisone	__	__	_________________	**Sulfa Drugs**	__	__	_________________
Demerol	__	__	_________________	**Other, please list:**	_________________		

MEDICAL HISTORY: please indicate: **S** (self), **F** (father), **M** (mother), **SI** (sister), **B** (brother), **G** (grandparent), **OFM** (other family member)

____Alcohol/Drug addiction/dependency
____Alzheimer's/Dementia
____Anemia – type_________________
____Arrhythmias – type _____________
____Arthritis - type_________________
____Asthma circle (adult or childhood)
____Bleeding/Clotting Problems – type_____
____Cancer - type___________________
____Depression/Anxiety disorder/Bipolar depression/other
____ Diabetes (how long? ____________)
____Emphysema/COPD
____Glaucoma
____Gout
____GERD (Reflux)/GI ulcers (circle)
____Headaches / Migraines
____Hearing Problems
____Heart Disease
____Hepatitis A B C/Liver Disease _____
____High Blood Pressure
____High Cholesterol
____ HIV/ Aids/ARC
____Kidney/ Renal Disease
____Lung Disease/Pulmonary Embolus
____Lyme's Disease
____Nervous Condition (type?)________
____Osteoporosis/Osteopenia (circle)
____Phlebitis (blood clots in legs)
____Pregnancy: are you currently pregnant? Due date: ________________
____Poor Circulation/PVD
____Rheumatic Fever/Scarlet Fever
____Schizophrenia
____Seizures/Epilepsy
____STD's (sexually transmitted ds.)
____Sickle Cell Trait/Disease
____Stroke/TIA's
____Thyroid Problems (Hyper__ Hypo__)
____Tuberculosis
____Other, Please Specify ____________
____Other, Please Specify ____________
____ NONE of the above

PLEASE FILL OUT COMPLETELY

<u>SMOKING</u>:
Do you or have you ever smoked? Y N
If yes, how many years? ______How long ago did you quit? _______

<u>RECREATIONAL DRUG USE</u>:
Do you or have you ever used illicit/recreational drugs? YES NO
If yes, which ones? _____________________________________
How long ago did you quit? _______________________________

<u>ALCOHOL USE</u>:
Do you or did you ever drink alcoholic beverages? Y N
How many drinks will you consume in a day? ____ Week? _____
How long ago did you quit? __________________________

<u>HOSPITALIZATION</u>: Y N If yes, please list: ____

<u>SURGICAL HISTORY</u>: Y N If yes, please list the surgeries you have had in the past 7 years:

____

Consent for Treatment: I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. By signing below, I hereby authorize Foot and Ankle Specialists of the Mid-Atlantic, LLC to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment. I give permission to Foot and Ankle Specialists of the Mid-Atlantic, LLC to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles, and lower legs.

Signature of Responsible Party____ **Date**___________________________

Relationship (if not patient) ____