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

SMOKING:
Do you or have you ever smoked? Y☐N☐
If yes, how many years? _____How long ago did you quit? _____

ALCOHOL USE:
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? _____

RECREATIONAL DRUG USE:
Do you or have you ever used illicit/recreational drugs? YES☐NO☐
If yes, which ones? _____
How long ago did you quit? _____

HOSPITALIZATION: Y☐N☐If yes, please list: _____
SURGICAL HISTORY: 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) _____