



FLORIDA FOOT AND ANKLE SPECIALISTS

Room #	X-ray Taken	<input type="checkbox"/> Yes <input type="checkbox"/> No	Xr/MRI/CT Brought	<input type="checkbox"/> Yes <input type="checkbox"/> No
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PATIENT HISTORY- PLEASE PRINT AND FILL OUT COMPLETELY

PERSONAL INFORMATION:

Name:		DOB:	Appt. Date:
Email:		Phone Number:	
Address:			
Age:	Height:	Weight:	Shoe Size:
Primary Care Physician:		Last seen date? (Approximate):	
Pharmacy name, address and phone number:			

HISTORY OF CURRENT CONDITION:

Why are you here for an evaluation today? (It is important to fill out this section. So we can best prepare for your visit.)

How long have you had this problem? Days Weeks Months Years

Is this problem getting better, worse, or staying the same?

Is the condition the result of an injury? Yes No **If yes, what was the date of the injury?**

Please describe how the injury occurred:

How do you rate your pain? (No Pain) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Severe Pain)

IS THE PAIN:			
<input type="checkbox"/> Constant	<input type="checkbox"/> Popping	<input type="checkbox"/> Unstable	<input type="checkbox"/> Burning
<input type="checkbox"/> Occasional	<input type="checkbox"/> Aching	<input type="checkbox"/> Present in bed	<input type="checkbox"/> Tingling
<input type="checkbox"/> Sharp	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Worse with walking/standing	<input type="checkbox"/> Numb
<input type="checkbox"/> Dull	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Worse with the first few steps out of bed	<input type="checkbox"/> Other:

LEFT RIGHT



WHICH SIDE HURTS? LEFT RIGHT BOTH

Please mark the area(s) affected above.

Have you experienced this problem in the past? Yes No

What makes your symptoms better?

What makes your symptoms worse?

WHAT OTHER TREATMENTS HAVE YOU TRIED:

<input type="checkbox"/> Rest	<input type="checkbox"/> Ice/heat	<input type="checkbox"/> Bracing/Arch Supports
<input type="checkbox"/> Injections	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Medication
<input type="checkbox"/> Other:		

Have you had any of the following tests? X-ray MRI CT Scan EMG/NCV Blood Test

Have you seen another foot/ankle doctor for this problem? Yes No Who?

Do you have any history of any prior foot/ankle injuries? Yes No

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes: years	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Arthritis	<input type="radio"/> Diet Controlled	<input type="checkbox"/> History of Blood Clots	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Asthma	<input type="radio"/> Insulin Dependent	<input type="checkbox"/> Keloid Formation	<input type="checkbox"/> Renal Disease
<input type="checkbox"/> Back Problems	<input type="radio"/> Oral Medication	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Skin Disorder
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Neurological Condition	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Bone/Joint Disorder	<input type="checkbox"/> Gout	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cancer:	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Osteopenia	<input type="checkbox"/> Vitamin Deficiency
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other:
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Hepatitis: A B C	<input type="checkbox"/> Pacemaker/Stimulator	<input type="checkbox"/> Other:
<input type="checkbox"/> COVID-19	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Other:

MEDICATIONS (PLEASE INCLUDE ANY SUPPLEMENTS AND VITAMINS)

CURRENT MEDICATIONS (NAME, STRENGTH AND DOSE):

1		6	
2		7	
3		8	
4		9	
5		10	

ALLERGIES (PLEASE ALSO LIST ANY DRUG INTOLERANCES)

Are you allergic to any medications? Yes No

Sulfa Latex Penicillin Tape Codeine

Other:

Please specify the type of reaction you had to the abovemedication(s):

LIST ALL PREVIOUS HOSPITALIZATIONS/SURGERIES **NONE**

PROCEDURE	COMPLICATIONS	YEAR

Have you had any complications with anesthesia in the past? Yes No **If yes, what type?** _____

FAMILY HISTORY:

	Alive	Health Issues/Cause of Death
Father:	<input type="checkbox"/>	
Mother:	<input type="checkbox"/>	
Brother(s): #	<input type="checkbox"/>	
Sister(s): #	<input type="checkbox"/>	
Children: #	<input type="checkbox"/>	
Other Family Medical History		

SOCIAL HISTORY:

What kind of work do you do? (Example: Student, secretarial, construction, teaching)			
What kinds of physical demands do you have on your feet due work, school, or other activities?			
What type of shoes do you typically wear?			
Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes , restrictions?		
Do you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit	If yes , how often?	Number	

REVIEW OF SYSTEMS (THESE ARE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING)

GENERAL	<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Muscle Wasting
<input type="checkbox"/> Chills	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Fatigue	ENDOCRINE	<input type="checkbox"/> Muscle Aches/Pains
<input type="checkbox"/> Fever	<input type="checkbox"/> Blood Sugar Problems	NEUROLOGICAL
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Increased Thirst	<input type="checkbox"/> Dizziness/Vertigo
CARDIOVASCULAR	<input type="checkbox"/> Increased Urination	<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> Leg Pains with walking	HEMATOLOGY	<input type="checkbox"/> Passing Out
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Motor Disturbances
<input type="checkbox"/> Palpitations	PSYCHIATRIC	SKIN
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Nail changes
<input type="checkbox"/> Leg Swelling	MUSCULOSKELETAL	<input type="checkbox"/> New Lesions/Ulcers
PERIPHERAL VASCULAR	<input type="checkbox"/> Joint pain or Stiffness	<input type="checkbox"/> Rashes
<input type="checkbox"/> Intermittent Claudication	<input type="checkbox"/> Joint Redness	Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No

PATIENT ASSESSMENT:

The physicians at Florida Foot and Ankle Specialists are concerned about your orthopaedic health and want to make sure that we are evaluating those factors which may impact your orthopaedic wellbeing. These questions help us improve your care and meet national quality reporting standards.

PLEASE CIRCLE AN ANSWER OR FILL IN THE BLANKS.

1. DIABETIC INTAKE

Do you have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last A1C:
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2. TOBACCO AND NICOTINE INTAKE

Do you currently use tobacco or nicotine products? <input type="checkbox"/> Never <input type="checkbox"/> Former user <input type="checkbox"/> Current user
If yes, how many packs per day and for how long?

3. COVID

Have you received a COVID-19 vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Prefer not to answer
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4. FALLS RISK SCREENING (ONLY AGE 65+)

Have you fallen 2 or more times in the past year, OR fallen once with injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel unsteady when walking? <input type="checkbox"/> Yes <input type="checkbox"/> No

5. ADVANCE CARE PLANNING (ONLY AGE 65+)

Do you have an advance directive (living will)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Have you designated someone to make medical decisions for you if needed (healthcare proxy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
If yes, Name:	Relationship:
<input type="checkbox"/> I prefer not to discuss advance care planning today	
<input type="checkbox"/> I would like more information about advance care planning	

How did you hear about us?

<input type="checkbox"/> Doctor Referral	<input type="checkbox"/> Church Bulletin	<input type="checkbox"/> Facebook
<input type="checkbox"/> Friend/Family	<input type="checkbox"/> Internet Research	<input type="checkbox"/> Zoc Doc
<input type="checkbox"/> Our Website	<input type="checkbox"/> Insurance Company	<input type="checkbox"/> Urgent Care/ER
<input type="checkbox"/> Other:		

PRINT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

I certify that the above medical information is accurate, up to date and complete.

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION:

I authorize **Florida Foot and Ankle Specialists** to discuss my appointments, treatment, medical condition, test results, and billing information with the following individuals:

Name:
Relationship:
Phone Number:

Name:
Relationship:
Phone Number:

EMERGENCY CONTACT (OPTIONAL)

If different, please complete below:

Name:
Relationship:
Phone Number:

RESTRICTION OPTION (OPTIONAL)

I do **NOT** authorize Florida Foot and Ankle Specialists to release my medical information to anyone other than as required for treatment, payment, or healthcare operations.

If checked, I understand that the office may only communicate directly with me regarding appointments, treatment, and billing unless otherwise required by law.

DURATION OF AUTHORIZATION

This authorization will remain in effect unless revoked by me in writing.

PATIENT SIGNATURE: _____

DATE: _____

