FLORIDA FOOT AND ANKLE SPECIALISTS

Room #		X-ray Taken	☐ Yes ☐ No	Xr/MRI/CT Brought	☐ Yes ☐ No

PATIENT HISTORY- PLEASE PRINT AND FILL OUT COMPLETELY

PERSONAL INFORMATION:

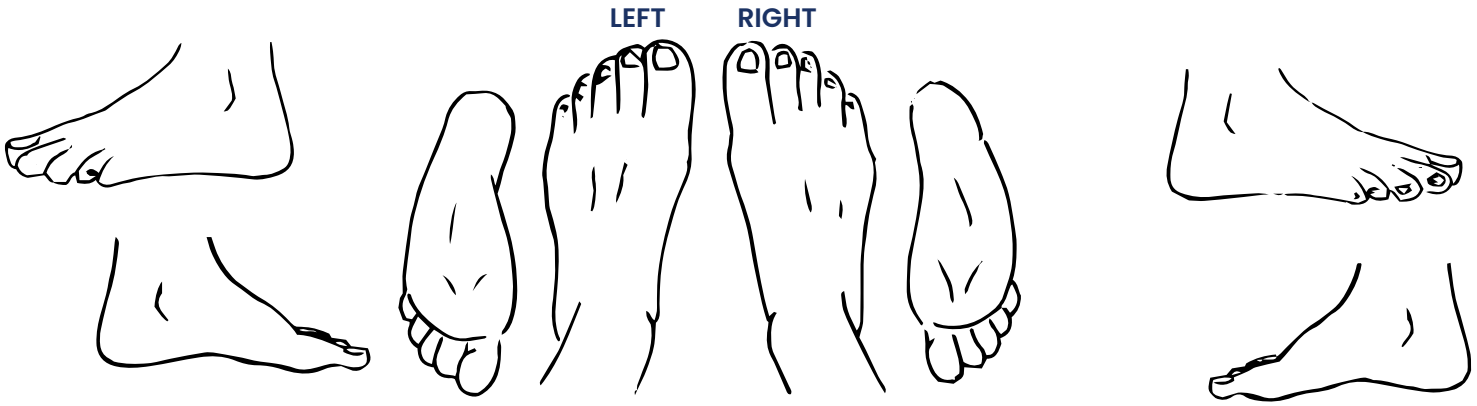
Name:		DOB:	Appt. Date:
Email:		Phone Number:	
Address:			
Age:	Height:	Weight:	Shoe Size:
Primary Care Physician:		Last seen date? (Approximate):	
Pharmacy name, address and phone number:			

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:							
☐	Constant	☐	Popping	☐	Unstable	☐	Burning
☐	Occasional	☐	Aching	☐	Present in bed	☐	Tingling
☐	Sharp	☐	Throbbing	☐	Worse with walking/standing	☐	Numb
☐	Dull	☐	Stabbing	☐	Worse with the first few steps out of bed	☐	Other:



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:					
☐	Rest	☐	Ice/heat	☐	Bracing/Arch Supports
☐	Injections	☐	Physical Therapy	☐	Medication
☐	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)

☐	Alcoholism	☐	Diabetes: years	☐	HIV/AIDS	☐	Poor Circulation
☐	Arthritis	◯	Diet Controlled	☐	History of Blood Clots	☐	Psychiatric Disorder
☐	Asthma	◯	Insulin Dependent	☐	Keloid Formation	☐	Renal Disease
☐	Back Problems	◯	Oral Medication	☐	Liver Disease	☐	Skin Disorder
☐	Bleeding Disorder	☐	Epilepsy/Seizures	☐	Neurological Condition	☐	Stroke/TIA
☐	Bone/Joint Disorder	☐	Gout	☐	Neuropathy	☐	Thyroid Disease
☐	Cancer:	☐	Heart Disease	☐	Osteopenia	☐	Vitamin Deficiency
☐	Chemical Dependency	☐	Heart Murmur	☐	Osteoporosis	☐	Other:
☐	COPD/Emphysema	☐	Hepatitis: A B C	☐	Pacemaker/Stimulator	☐	Other:
☐	COVID-19	☐	High Blood Pressure	☐	Peripheral Vascular Disease	☐	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:	☐	
Mother:	☐	
Brother(s): #	☐	
Sister(s): #	☐	
Children: #	☐	
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, orother activities?			
What type of shoes do you typically wear?			
Are you on a special diet? ☐ Yes ☐ No	If **yes**, restrictions?		
Do you drink? ☐ Yes ☐ No ☐ Quit	If **yes**, how often?	Number	

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

GENERAL	☐ Leg Cramps	☐ Muscle Wasting
☐ Chills	☐ Varicose Veins	☐ Muscle Weakness
☐ Fatigue	**ENDOCRINE**	☐ Muscle Aches/Pains
☐ Fever	☐ Blood Sugar Problems	**NEUROLOGICAL**
☐ Weight Change	☐ Increased Thirst	☐ Dizziness/Vertigo
CARDIOVASCULAR	☐ Increased Urination	☐ Numbness/Tingling
☐ Leg Pains with walking	**HEMATOLOGY**	☐ Passing Out
☐ Chest Pain	☐ Bleeding Problems	☐ Motor Disturbancs
☐ Palpitations	**PSYCHIATRIC**	**SKIN**
☐ Shortness of Breath	☐ Anxiety/Depression	☐ Nail changes
☐ Leg Swelling	**MUSCULOSKELETAL**	☐ New Lesions/Ulcers
PERIPHERAL VASCULAR	☐ Joint pain or Stiffness	☐ Rashes
☐ Intermittent Claudication	☐ Joint Redness	**Are you Pregnant?** ☐ **Yes** ☐ **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? ☐ Yes ☐ No	Last A1C:

2. TOBACCO AND NICOTINE INTAKE

Do you currently use tobacco or nicotine products? ☐ Never ☐ Former user ☐ Current user
If yes, how many packs per day and for how long?

3. COVID

Have you received a COVID-19 vaccine? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to answer

4. FALLS RISK SCREENING (ONLY AGE 65+)

Have you fallen 2 or more times in the past year, OR fallen once with injury? ☐ Yes ☐ No
Do you feel unsteady when walking? ☐ Yes ☐ No

5. ADVANCE CARE PLANNING (ONLY AGE 65+)

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

How did you hear about us?

☐	Doctor Referral	☐	Church Bulletin	☐	Facebook
☐	Friend/Family	☐	Internet Research	☐	Zoc Doc
☐	Our Website	☐	Insurance Company	☐	Urgent Care/ER
☐	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:	Name:
Relationship:	Relationship:
Phone Number:	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:** _____