Foot & Ankle Specialists of NM

Patient Name ____ DOB__________ Gender M F Date _____________

Primary Care Physician refer you? ◻ **Yes** ◻ **No** **First, Last Name of Primary Care Doctor:**

Reason for your visit today: ____

When did problem start? ____

Previous Treatment by? _________________________________ Are you in hospice? Y N

Are you currently residing in a Skilled Nursing Facility, Nursing Home, Rebab Facility? Y N

If yes to the above, please indicate the name of the facility: ____

Check all treatments received for this condition:

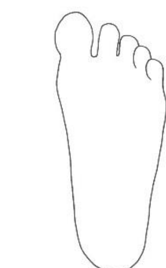
◻ Pain Medication ◻ Antibiotics ◻ MRI
◻ Injection ◻ Surgery ◻ CT Scan
◻ X-rays ◻ Bone Scan ◻ Hospitalization
◻ Physical Therapy ◻ Ice/Stretching ◻ Other______________________________

<u>Tell me about your pain</u>:

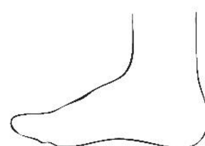
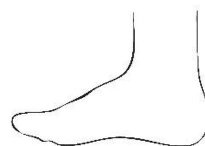
How long ago did this problem first start? _____________ Days / Weeks / Months / Years
Did your pain or problem: ◻ Begin all of a sudden ◻ Gradually develop over time
How would you describe your pain? ◻ No Pain ◻ Sharp ◻ Dull ◻ Aching ◻ Burning ◻ Radiating
◻ Itching ◻ Stabbing ◻ Other:___________________________________
How would you rate your pain on a scale from 1-10? (Circle Please)
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)
Since the time you pain or problem began, has it: ◻ Stayed the Same ◻ Became Worse ◻ Improved
What makes your pain or problem feel worse? ◻ Walking ◻ Running ◻ Standing ◻ Daily Activities ◻ Resting
◻ Dress Shoes ◻ High Heels ◻ Flat Shoes ◻ Any Closed Toes Shoes ◻ Other __________________________
What makes your pain or problem feel better? ____
What treatments have you had for this problem? ____
How has the problem affected your lifestyle or ability to work? ____
Was this problem caused by an injury? ◻ Yes (Describe) ______________________________________ ◻ No
If yes, was it a work-related injury? ◻ Yes ◻ No

Where is the pain/problem located? Please mark on pictures below.

LEFT FOOT RIGHT FOOT



TOP OF FOOT BOTTOM OF FOOT BOTTOM OF FOOT TOP OF FOOT

INSIDE OF FOOT OUTSIDE OF FOOT OUTSIDE OF FOOT INSIDE OF FOOT

Patient Name DOB Date

►Drug Allergies

□ None or List all known

Allergies____

►Current Medications

□ None or See List Below (or attach list, if nec)

Medication Name	Dose (mg, units, etc)	How Often/When

►Patient Medical History

Have you been diagnosed with any of the following? Please circle all that apply:

- Anemia
- Arthritis
- Asthma
- Back Problems
- Blood Clots
- Cancer_________________
- Depression
- **Diabetes 1 Yes No**
- **Diabetes II Yes No**
- **Are you taking insulin? Yes No**
- Emphysema
- Fibromyalgia
- GERD

Glaucoma
Gout
Heart Attack
High Blood Pressure
HIV/AIDS
Heart Disease
Hepatitis A/B/C
High Cholesterol
Irregular Heartbeat
Kidney Stones
Kidney Disease
-- Are you on dialysis? Yes No

Liver Disease
Sleep Apnea
Stroke
Stomach Disorders
Ulcers/Reflux
Thyroid Disorder
Tuberculosis
Parkinsons
Cerebral Palsy
Dementia
Osteoarthritis
Rheumatoid Arthritis

►Previous Surgeries □ None or Please list procedure and date performed

____

____

____

► Family History

Please answer the following:

Has anyone in your immediate family been diagnosed with any of the following?

□ Stroke Which family member?_______________________________

□ Arthritis Which family member?_______________________________

□ Cancer Which family member?_______________________________

□ Diabetes Which family member?_______________________________

□ Heart Disease Which family member?_______________________________

□ High Blood Pressure Which family member?_______________________________

Patient Name DOB Date

► Social History

Please answer the following:

- Occupation ________________________ Special footwear or long hours on feet all day? How much?_________
- Use of Alcohol? □ No □ Yes (If yes, how much/frequently?__________________________
- Use of Tobacco? □ No □ Yes (If yes, how much/frequently?__________________________
- Use of Recreational Drugs? □ No □ Yes (If yes, how much/frequently?__________________________

► Review of Systems

Please check all conditions and symptoms that you currently have:

General:	__Fever	__Fatigue	__Sleeping Problems	__Weight loss/gain
Skin:	__Rash	__Itching	__Lesions/Sores	__Dry skin
Head:	__Injury	__Headache	__Changes	__Vision Problems
Eyes:	__Blurry vision	__Double Vision	__Pain or Itching	__Glasses/Contacts
Ear/Nose/Throat	__Ringing ears	__Hearing Loss	__Sinus congestion	__Hoarseness
Lungs:	__Cough	__Shortness of breath	__Snoring	__Wheezing
Heart:	__Chest pain	__Iregg heart beat	__Murmur	__Palpitations
Digestive:	__Nausea	__Vomiting	__Constipation	__Diarrhea
Urinary:	__Frequency	__Incontinence	__Burning	__Bleeding
Musculoskeletal:	__Joint pain	__Muscle weakness	__Joint Stiffness	__Deformity
Peripheral Vascular:	__Calf pain	__Leg cramps	__Swelling	__Varicose veins
Neurological:	__Numbness	__Seizures	__Dizziness	__Weakness
Psychiatric:	__Anxiety	__Depression	__Mood Swings	__Nervousness
Endocrine:	__Diabetes	__Thyroid	__Excessive Sweating	__Hair Loss
Hematological:	__Anemia	__Bruise easily	__Bleeding tendency	__Cold feet or hands
OB/GYN:	__Pregnant	__Birth control pills	__Hormone therapy	__Menopausal

► Vitals

Weight______________________________ Height___________________________ Shoe Size________________________

____Pa

Patient Signature (Parent or Guardian if patient under 18 years old) Date:

Witness's Signature: ____ Date: _______________________

Clinical Staff: ____ Date: _______________________

*********THIS SECTION TO BE COMPLETED DURING NEXT CALENDAR YEAR*********

Patient has reviewed, updated and initialed the Medical History contained herein on the date of: _______/________/________

_______________________________________ _______________________________________

Patient Signature Or Guarantor Signature

Patient has reviewed, updated and initialed the Medical History contained herein on the date of: _______/________/________

_______________________________________ _______________________________________

Patient Signature Or Guarantor Signature