**MEDICAL HISTORY FORM** **Advanced Foot and Ankle of WI, LLC**

**Patient Name**:_____
First MI Last

**PRESENT ILLNESS OR INJURY**

**What is the reason (problem) for your visit to our office?**_____

**Who is your Primary Care Physician?**_____ **Date last seen?**_____

**Have you seen this or any other physician regarding this problem?** ☐ NO ☐ YES

**If YES, please state which doctor and when?**_____

**How were you referred to our practice?** ☐ Doctor Referral – who?_____

☐ TV Commercial ☐ Health Fair ☐ Family/Friend ☐ Listed in your insurance guide

☐ Other, explain:_____

**MEDICAL HISTORY**

**What is your current smoking status**? ☐ Currently smoke ☐ Occasional ☐ Former Smoker ☐ Never smoked

**Please indicate which Foot/Ankle problems you now have or have had in the past:**

☐ Ankle Pain
☐ Athlete's Foot
☐ Bunions
☐ Corns and Calluses
☐ Cramps in Foot/Legs
☐ Flat Feet
☐ Heel Pain
☐ Ingrown Toenails
☐ Numbness in Feet, Legs, Toes
☐ Plantar Warts
☐ Swelling in Feet, Legs, Toes
☐ Tired Feet

**Have you been diagnosed with any of the following: (you must indicate Yes or No)**

| | | |
|---|---|---|
| Diabetes | Yes ☐ | No ☐ |
| Hypertension | Yes ☐ | No ☐ |
| Peripheral Vascular Disease | Yes ☐ | No ☐ |
| Onychomycosis | Yes ☐ | No ☐ |
| Plantar Fasciitis | Yes ☐ | No ☐ |

**Have you been prescribed a foot orthotic?** ☐ Yes ☐ NO If Yes, do you still use them? ☐ Yes ☐ No

**ALLERGIES**

**Please tell us of any allergies you have and potential reactions (i.e. Nausea, hives) when encountered:**

☐ Aspirin:_____ ☐ Novocain:_____

☐ Codeine:_____ ☐ Penicillin:_____

☐ Demerol:_____ ☐ Sulfa:_____

☐ Iodine:_____ ☐ OTHER:_____

**MEDICATIONS**

**Please list any medications you are currently taking. If you require more space or would like a list of common medications, please ask our receptionist to provide one.**_____

_____

**SURGICAL / INJURY HISTORY**

**Please list the type of surgery and date**:_____

_____

**Please list injuries that required medical attention or hospitalization and the date**:_____

_____

**PATIENT HISTORY**

**Please mark Yes or No to indicate you have/have not had any of the following:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| AIDS/HIV | ☐ | ☐ | Kidney Problems | ☐ | ☐ |
| Allergies to Anesthetics | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Neuropathy | ☐ | ☐ |
| Artificial Heart Valves or Joints | ☐ | ☐ | Psychiatric Care | ☐ | ☐ |
| Back Problems | ☐ | ☐ | Radiation Treatment | ☐ | ☐ |
| Bleeding Disorders/ Blood Disorders | ☐ | ☐ | Rash | ☐ | ☐ |
| Cancer | ☐ | ☐ | Respiratory Disease | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Chest Pain | ☐ | ☐ | Shortness of Breath | ☐ | ☐ |
| Circulatory Problems | ☐ | ☐ | Stroke | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Swelling in Ankles, Feet | ☐ | ☐ |
| Foot or Leg Cramps | ☐ | ☐ | Swollen Neck Glands | ☐ | ☐ |
| Gout | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Headaches | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | Varicose Veins | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Venereal Disease | ☐ | ☐ |

**Is there a history in your family of any of the conditions shown above? ☐ Yes ☐ No**

**If Yes, please describe and include relationship:**_____

_____

**Are you now or have you been under another doctor's care for any reason in the last two years?** ☐ YES ☐ NO

**If Yes, please indicate for what reason**:_____

**Shoe size?**_____

**Height?**_____ **What is your preferred Pharmacy?**

**Weight?**_____ **Name:**_____

**Blood Pressure?**_____ **Location:**_____

**TREATMENT CONSENT**

**I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.**

_____ _____

**Signature of Patient, Guarantor, or Responsible Party** **Print name**

_____ _____

**Date** **Relationship to Patient**