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 Type 1 ☐ Type 2 ☐ 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?__________________________________

Weight?__________________________________

Blood Pressure?___________________________

What is your preferred Pharmacy?

Name:___________________________________

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**