ADVANCED FOOT & ANKLE

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LAST:	FIRST:	MIDDLE:
SS #:	DOB (XX/XX/XXXX):	SEX: M F

ALLERGIES

LIST ALL KNOWN ALLERGIES (DRUG, FOOD, TAPE, ANIMALS, MATERIALS, ETC.)

CURRENT MEDICATIONS

LIST ALL CURRENT MEDICATIONS, INCLUDE DOSAGE IF KNOWN

PAST & PRESENT ILLNESSES

- ☐ Any recent illness:
- ☐ Asthma
- ☐ Arthritis
- ☐ Back Trouble
- ☐ Bleeding or Blood Disorders
- ☐ Broken Bones of Head, Neck, Spine
- ☐ Cancer:
- ☐ Cataracts or Glaucoma
- ☐ Colitis
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Heart Problems
- ☐ Hepatitis or Jaundice
- ☐ High Blood Pressure
- ☐ HIV or AIDS
- ☐ Hypoglycemia (Low Blood Sugar)
- ☐ Influenza Vaccine in Last 12 Months
- ☐ Kidney, Bladder, Prostate Problems
- ☐ Liver Disease
- ☐ Lung Problems:
- ☐ Osteoporosis
- ☐ Mental Health Problems or Phobias
- ☐ Muscle Disorders
- ☐ Pneumovax Vaccine
- ☐ Neurological Problems:
- ☐ Exposure to Communicable Disease
- ☐ Rheumatic Fever
- ☐ Severe Headaches
- ☐ Skin Problems:
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Stomach Problems:
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Other:

MAJOR SURGERIES

LIST ANY MAJOR SURGERIES THAT YOU HAVE HAD, INCLUDE YEAR OF SURGERY

FAMILY HISTORY

Cancer?	☐ Yes ☐ No	Relation: _____	Deep Vein Thrombosis (DVT)?	☐ Yes ☐ No	Relation: _____
Diabetes?	☐ Yes ☐ No	Relation: _____	Pulmonary Embolism (PE)?	☐ Yes ☐ No	Relation: _____
Hypertension?	☐ Yes ☐ No	Relation: _____	Surgical Complications?	☐ Yes ☐ No	Relation: _____

FOOT & ANKLE PROBLEMS

CHECK FOOT & ANKLE PROBLEMS THAT YOU HAVE HAD OR ARE CURRENTLY EXPERIENCING

- ☐ Ankle Sprain
- ☐ Ankle Instability
- ☐ Arch Pain
- ☐ Athlete's Foot
- ☐ Broken Ankle
- ☐ Broken Foot Bones
- ☐ Bunions
- ☐ Broken Bones of Head, Neck, Spine
- ☐ Childhood Foot Problems
- ☐ Corns or Calluses
- ☐ Cramps in Legs or Feet
- ☐ Flat Feet
- ☐ Gait (Walking) Problems
- ☐ Foot Numbness
- ☐ Fungal Nails
- ☐ Hammer or Mallet Toes
- ☐ Heel Pain
- ☐ High Arch Feet
- ☐ In-Toeing
- ☐ Ingrown Nails
- ☐ Knee Pain
- ☐ Leg or Foot Ulcers
- ☐ Lower Back Pain
- ☐ Neuroma
- ☐ Rash (Foot, Ankle, Toes, Etc.)
- ☐ Toe Walking
- ☐ Other:

INSERTS, ORTHOTICS, & ACTIVITY

ANSWER THE FOLLOWING QUESTIONS CONCERNING INSERTS, ORTHOTICS, AND YOUR ACTIVITY

Have You Used Inserts?	☐ Yes ☐ No	Still Using?	☐ Yes ☐ No	Do/Did The Inserts Help?	☐ Yes ☐ No
Have You Used Orthotics?	☐ Yes ☐ No	Still Using?	☐ Yes ☐ No	Do/Did The Orthotics Help?	☐ Yes ☐ No
Are Your First Steps Out Of Bed Painful?	☐ Yes ☐ No			Does the Pain Subside?	☐ Yes ☐ No
Do You Get Leg Cramps During the Day?	☐ Yes ☐ No			Do You Get Leg Cramps at Night?	☐ Yes ☐ No

Percent of Waking Hours Spent on Feet? _____

List Sports and Activities You Participate In: _____

PATIENT/GUARDIAN SIGNATURE:	DATE SIGNED: