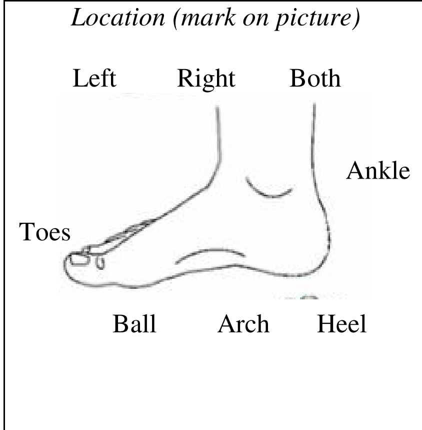
FOOT & ANKLE CENTER OF NW PA

Patient Name:_________________________________ Age:__________ Date of Birth:________________________________
Referring Physician:___________________________________Date of Last Visit:_____________________________________
Height:______________________ Weight:____________________ Shoe Size:___________________________________
SS # ___________________________Place of employment: ____
Next of Kin or Emergency Contact: ____ Phone # ___________________________
Reason for Today's Visit:____

SYMPTOMS (Please describe):

Location (mark on picture)



Quality (circle):
Dull
Achy
Throbbing
Burning
Sharp
Shooting
Stabbing
Pins & Needles

Duration:	**Onset:**	**Aggravated By:**	**Course Progression**	**Previous Work-up**
Days	Slow	Running	Worsening	X ray
Months	Sudden	Walking	Improving	MRI
Years	Traumatic	Standing		CT
		Shoes		Bone Scan

Therapies Tried:

Different Shoes	orthotics	elevation	Cushion/Pads
Medicines:___________		Ice	

Past Medical History: (circle)

High Blood Pressure	Heart Valve	Anemia	Kidney Disease	Herniated Disc
Heart Disease	Diabetes	Arthritis	Neuropathy	Pneumonia
A-Fib	COPD	Osteoporosis	Cancer	Pulmonary Embolism
CAD	Stroke	Clotting Disorders	Congestive Heart Failure	Rheumatic Fever
Mitral Valve Prolapse	Hepatitis	Asthma	Fibromyalgia	Seizure Disorder
Heart Murmur	Stomach Ulcer	HIV Positive	Gout	Sickle Cell Anemia

Prior Surgeries: (list)

_______________________ \
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Medications: (photocopy or list)

Name	Dosage
_____________________	_____________
_____________________	_____________
_____________________	_____________
_____________________	_____________

Allergies: (circle)

Adhesive/tape	Local Anesthesia
Aspirin	Penicilliam
Codeine	Seafood
Iodine	Sulfa

Other_______________________________
____

Social History: (list)

Tobacco: Yes No
Years Smoked ____________
Alcohol Yes No
Amount: _________________
Drugs Yes No
Type:____________________

Family History: (circle)

Arthritis	Diabetes	Malignant Hyperthermia
Cancer	Gout	Seizure Disorder
Stroke	Heart Disease	Sickle Cell Anemia
Clotting Disorder	High Blood Pressure	Other
Congestive Heart Failure	Hyperthyroidism	
COPD	Kidney Disease	

Any Additional Information for Today's Visit?

Patient Signature____**Date**________________________________