Dr P__ Dr V__ Dr N__
(Office Use Only)

Advanced Foot and Ankle Surgeons, Inc.

Date:___/___/___ **Age:_____**

Patient Name:_____ Date of Birth_____/____/_____

- ❑ Male
- ❑ Female

Home Address: _____

City/State:_____ Zip:_____

Please indicate yes or no below where we can leave messages regarding your care, confidential information, & appointments.

Home Phone:_____**Yes/ No** Email:_____**Yes/ No**

Cell Phone:_____**Yes/ No** Work Phone:_____**Yes/ No**

Preferred Language:_____ **Ethnicity**: Non-Hispanic ____ Hispanic ____ Other_____

Race: American Indian/Alaska Native___ Asian ___ Black/African American___ Hispanic/Latino__

White/Caucasian___ Pacific Islander/Native Hawaiian___

Do you have a legal guardian or power of attorney? **Yes/ No**

If yes, Name: _____ Relationship:_____ Phone:_____

Is there a family member or person you would like us to share your medical information with? Yes No

Name(s):_____

If Under 18 years of age:

Mom's Name:_____ Dad's Name:_____

Mom's Address: _____ City:_____ State/Zip:_____

Dad's Address:_____ City:_____ State/Zip:_____

Who is responsible for payment? _____

Date of Birth: _____ Relationship to patient:_____

Address:_____City/State:_____

Zip:_____

Phone:_____

Patient Name:_____

How did you hear about our office?

- ❑ Patient
- ❑ Newspaper
- ❑ Friend
- ❑ Insurance
- ❑ Internet
- ❑ Family
- ❑ Yellow Book
- ❑ Home Pages
- ❑ Other_____
- ❑ Doctor Referral, Dr. _____

INSURANCE INFORMATION

Primary Insurance Carrier:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Member ID#:_____ Group #:_____

Secondary Insurance Carrier:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Member ID#:_____ Group #:_____

IS YOUR PROBLEM DUE TO A WORK INJURY?

YES / NO

**** Please notify receptionist if your problem is a work related injury****

- ❑ I am not taking any medications
- ❑ I have provided a list of my medications

MEDICATION LIST

Name: **Dose:** **How Often:**

Patient Name:_____

ALLERGIES (List any allergies and state your reaction. If the onset date is known, please list.)

- ❑ I have no known allergies to medications
- ❑ I am unsure if I have allergies to medications

- ❑ Penicillin:_____
- ❑ Sulfa:_____
- ❑ Iodine/Shellfish:_____
- ❑ Codeine:_____
- ❑ Novocain/Local Anesthesia:_____
- ❑ Other:_____
- ❑ Latex:_____
- ❑ Adhesive Tape:_____

Height:_____ Weight:_____ Shoe Size:_____ Pharmacy & Location:_____

Primary Care Doctor (First & Last Name):_____ City:_____

Date Last Seen by Doctor:_____ Phone:_____

SURGICAL HISTORY

Date:	**Type:**	**Surgeon:**	**Location:**

Patient Name:_____

SOCIAL HISTORY

Marital Status:

- ❑ Never Married
- ❑ Married
- ❑ Annulled
- ❑ Widowed
- ❑ Separated
- ❑ Divorced

Employment Status:

- ❑ Employed
- ❑ Unemployed
- ❑ Retired
- ❑ Child
- ❑ Other
- ❑ Part-time Student
- ❑ Full-time Student

Employer & Occupation_____

How much are you on your feet at work? 10% 25% 50% 75% 100%

Use of Alcohol:

- ❑ Beer
- ❑ Wine
- ❑ Hard Liquor

How much and how often?_____

Use of Tobacco:

- ❑ Cigarettes
- ❑ Cigars
- ❑ Pipe
- ❑ Chewing Tobacco
- ❑ Dipping Tobacco

Daily Usage:_____ If you quit, when and how long did you use?_____

Patient Name:_____

DIABETICS

Who is the doctor managing your diabetes?_____

Are you taking insulin?

- ❑ Yes
- ❑ No

How many years have you been diabetic?_____

Last hemoglobin A1c:____ Highest and lowest blood sugar level in past month:_____

Have you ever had a foot/leg ulcer?

- ❑ Yes
- ❑ No

If yes, where?_____

How long did you have an ulcer?_____

Do you have an ulcer now?

- ❑ Yes
- ❑ No

If yes, describe where, duration, and treatment:_____

Have you ever been told you have poor circulation in your feet?

- ❑ Yes If yes, describe: _____
- ❑ No

Have you ever been told you have poor sensation in your feet?

- ❑ Yes If yes, describe:_____
- ❑ No

Have you ever had diabetic shoes with inserts?

- ❑ Yes If yes, when & where did you get your last pair? _____
- ❑ No

Patient Name:_____

MEDICAL HISTORY (Please indicate if you or any of your family members have these conditions.)

X	Self
M	Mother
F	Father
B	Brother
S	Sister
PGF	Paternal Grandfather
PGM	Paternal Grandmother
MGF	Maternal Grandfather
MGM	Maternal Grandmother
U	Unknown

_____ Acid Reflux
_____ Anemia
_____ Arthritis
_____ Asthma
_____ Back Problems
_____ Blood Clots
_____ Cancer
_____ Diabetes
_____ Foot Pain
_____ Gout
_____ Heart Attack
_____ Heart Disease/Failure
_____ Hepatitis
_____ HIV+/AIDS
_____ High Blood Pressure
_____ Kidney Disease
_____ Liver Disease
_____ Neuropathy
_____ Open Sores
_____ Pneumonia
_____ Skin Disorder
_____ Stomach Ulcers
_____ Stroke
_____ Thyroid Disease
_____ Numbness/Tingling in Feet

Patient Name:_____

CHIEF COMPLAINT

What problem brings you to the office today? List location and a brief description.

Problem #1:_____

Location:_____ When did you first experience this problem?_____

What treatment have you had?_____

Problem #2:_____

Location:_____ When did you first experience this problem?_____

What treatment have you had?_____

Problem #3:_____

Location:_____ When did you first experience this problem?_____

What treatment have you had?_____

Were any of these problems caused by an injury?

- ❑ Yes If yes, describe _____
- ❑ No

Patient/ Guardian Signature: _____ **Date:** _____

Thank you from Advanced Foot & Ankle Surgeons, Inc!

Updated 2020

(For office use)

- ❑ **Scanned**