

The Foot and Ankle Wellness Center of Western Pennsylvania

Today's Date: ____/____/____

Patient Number: _____

Patient Name: _____ Sex: _____ Age: _____

Describe Your Foot Problem: _____

Have you had any previous foot care or surgery? _____

If yes, by whom? _____ How Long Ago: _____

Primary Care Physician: _____ Date Last Seen: ____/____/____

General Health

Blood Pressure: ____/____ Height: _____ Weight: _____ Lbs. Shoe Size: _____
(Please check any of the following which **you** and **your family** have been or are being treated.)

Self	Family		Self	Family	
_____	_____	Asthma	_____	_____	Cardiac Disease
_____	_____	Arthritis (Type)	_____	_____	Glaucoma/Eye
_____	_____	Mitral Valve Prolapse (Heart Murmur)	_____	_____	Breathing Problems
_____	_____	Scarlet Fever	_____	_____	Venereal Disease
_____	_____	Hypertension (High blood Pressure)	_____	_____	Hemophilia (Bleeder)
_____	_____	Peripheral Vascular Disease (Circulation)	_____	_____	Stomach Problems (Ulcer)
_____	_____	Tuberculosis	_____	_____	Renal Disease (Kidney)
_____	_____	Gout	_____	_____	Polio, Cerebral Palsy, Muscular Dystrophy
_____	_____	Cerebral Accident (Stroke)	_____	_____	Phlebitis/Thrombophlebitis (Clot)
_____	_____	Diabetes	_____	_____	Anemia (Blood Disorder)
_____	_____	Liver Disease (Hepatitis)	_____	_____	Thyroid Disease (Hypo or Hyper)
_____	_____	Epilepsy (Convulsions)	_____	_____	Slow Healer
_____	_____	HIV Positive (Aids)	_____	_____	Previous Blood Transfusion (If yes, When?)
_____	_____	Other – Please state _____			

Woman Are you Pregnant? _____ LMP: _____ Due Date: ____/____/____

Allergies

Are you allergic to any of the below? Please check below:

_____ Penicillin	_____ Tetracycline	_____ Aspirin
_____ Sulfa Drugs	_____ Novocaine	_____ Codeine
_____ Barbiturates	_____ Cortisone	_____ Iodine Dyes
_____ Foods	_____ Adhesive Tape	_____ Other:
_____ Environmental	_____ Caffeine	_____

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Personal Social History

Tobacco: _____ per Day: _____ Years: _____

Alcohol: _____ oz. per week: _____ Caffeine: _____ Cups per Day

Recreational Drugs: _____ Name of Drug(s): _____

Occupation: _____

Activities: _____ Exercise: _____

Medications

Are you taking any medication(s)? Yes: _____ No: _____ If Yes Please List Below:

(Please include your prescription medication, Vitamins, Birth Control Pills, Herbs and any over the counter Medications)

- _____ 1. _____
- _____ 2. _____
- _____ 3. _____
- _____ 4. _____
- _____ 5. _____
- _____ 6. _____
- _____ 7. _____
- _____ 8. _____
- _____ 9. _____
- _____ 10. _____

Surgical or Hospitalization History

Have you had any surgery intervention or hospitalization? Yes: _____ No: _____

If yes please list: _____

Consent for Treatment

The above information is correct to the best of my knowledge and consent to such diagnosis procedures (including x-rays) and medical care and treatment as deemed necessary by The Foot and Ankle Wellness Center of Western Pennsylvania.

X: _____
Signature of Patient or Consenter

Date: ____ / ____ / ____

X: _____
Witness

Consent of Photography

I hereby authorize The Foot and Ankle Wellness Center of Western Pennsylvania to take medical photographs which are to be used solely for the purpose of education.

X: _____

Date: ____ / ____ / ____