Family Foot & Ankle Specialists, LLC

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www.stopfootpainfast.com

WE ARE VERY PLEASED TO HAVE YOU WITH US!

Please answer the following questions to help us become acquainted.

Date ______________________ Referred by ______________________

Name ______________________ Age __________ Birthdate ______________________

SS# ______________________ Driver's Lic # ______________________ Sex: M F Marital Status: M S D W

Race ______________________ Language ______________________

Ethnicity ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ None ☐ Decline

Address ______________________ City ______________________ State __________ Zip __________

Home # ( ) ______________ Business # ( ) ______________ Cell # ( ) ______________

E-Mail Address ______________________ Employer ______________________

Address ____

Name of Pharmacy ______________________ Name of Spouse or Parent (if minor) ______________________

Name of Insurance ______________________ Name of Insured ______________________

Insured's S. S. # ______________________ Insured Date of Birth ______________________

Family Doctor's Name & Address ____

Date last seen by family physician ____

Have you had previous foot treatment? ______________ When? ______________________

What is your foot problem? ____

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Height ______________ Weight ______________ Shoe Size ______________ Width ______________

FOR EMERGENCIES, PLEASE SUPPLY:

Spouse's Employer ______________________ Spouse's Business Phone ( ) ______________________

FAMILY HISTORY	**YES**	**NO**
Does heart trouble run in your family?	☐	☐
Does diabetes run in your family?	☐	☐
Does high blood pressure run in your family?	☐	☐
Does epilepsy run in your family?	☐	☐
Do bleeding disorders run in your family?	☐	☐
Do ulcers run in your family?	☐	☐

PERSONAL HISTORY

If you have, or have had, any of the following, please check:

☐ Diabetes
☐ Heart Trouble
☐ High Blood Pressure
☐ Rheumatic Fever
☐ Kidney Trouble
☐ Tuberculosis
☐ Urinary Disorders
☐ Hepatitis
☐ Other ______________________

☐ Stomach Ulcers
☐ Liver Trouble
☐ Leg Cramps
☐ Anemia
☐ Asthma
☐ Stroke
☐ Nerve Disorders
☐ Fractures (broken bones) Where & When

☐ Bleeding Disorders
☐ Polio
☐ Cancer
☐ Epilepsy
☐ Arthritis or Gout
☐ Phlebitis

Smoking ☐ Yes ☐ No

How many packs/day? __________

ALLERGIES Have you ever experienced any ill effects from the following:

- ☐ Novocaine
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Iodine (shellfish)
- ☐ Adhesive Tape
- ☐ Aspirin
- ☐ Antibiotics (type) ______________________

Allergies to any other medication (name?) ______________________

____

Type of reaction (nausea, hives, difficulty in breathing, etc)? ______________________

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____

MEDICATIONS: What medications do you take or have you taken in the last six months?

Blood pressure medication	Name ______________________
Medicine for your blood	Name ______________________
Heart medicine	Name ______________________
Diabetes medicine	Name ______________________
Vitamins	Name ______________________
Thyroid medicine	Name ______________________
Circulation medicine	Name ______________________
Nerve/Tranquilizer medicine	Name ______________________
Other medicine	Name ______________________

SURGICAL HISTORY	**YES**	**NO**
Have you ever had any operations?	☐	☐
Have you ever had any operations on your feet?	☐	☐

If yes, please list the type(s) of surgery and the date(s) performed ______________________

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I hereby give permission to Dr. Wishnie, Dr. Kosofsky, Dr. Waters, Dr. Volosov and Dr. Schaeffer to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my ankle/foot condition.

Date ______________________ Signature ______________________

(If patient is a minor, parent or guardian must sign)