

# Atlantic Foot & Ankle Associates

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Please Print**

**Podiatric History**

What is the chief complaint for which you came to be treated? \_\_\_\_\_

When did it start? \_\_\_\_\_

What treatment have you tried? \_\_\_\_\_

**Do you smoke?**  yes  no **If yes, how many packs a day?** \_\_\_\_\_ **How many years?** \_\_\_\_\_

Shoe Size \_\_\_\_\_ Ht. \_\_\_\_\_ Wt \_\_\_\_\_

Place a mark on “Yes” to the left of each item if you have any of these conditions.

Yes		Yes		Yes	
	AIDS/HIV		Circulatory problems		High Cholesterol
	Anemia		Depression		Hypothyroidism
	Angina		Diabetes		Kidney problems
	Arthritis		Emphysema		Liver Disease
	Artificial heart Valve		Epilepsy		Phlebitis
	Artificial Joint		Eye Problems		Radiation therapy
	Asthma		Fainting		Respiratory Disease
	Back problems		Fibromyalgia		Rheumatoid arthritis
	Bleeding Disorder		Foot and leg Cramps		Shortness of breath
	Bronchial problems		Gout		Special diet
	Cancer		Heart disease		Stroke
	Chemical Dependency		Hemophilia		Swelling in ankles and feet
	Chest pain		Hepatitis or jaundice		Tuberculosis
	Chronic Pain Syndrome		High blood pressure		Ulcers
	history of blood clot/DVT		Varicose Veins		

Additional past Medical History: \_\_\_\_\_

Surgeries (Include all): \_\_\_\_\_

Hospitalization other than surgeries: \_\_\_\_\_

Have you been under the care of any other doctor in the past 2 years  yes  no

If yes, please explain \_\_\_\_\_

**ALLERGIES:** Yes or No If yes please list \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Pharmacy Phone:** \_\_\_\_\_

**Medications** (include prescription, over the counter & vitamins):

Medication Name


**Consent**

I certify that the above information is true to the best of my knowledge. I give my permission to the doctor to administer and perform such procedure as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_