Advanced Foot and Ankle of Indian River
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Patient Name: ____ DOB: _______________________ Date: _____ /_____ /______

Reason for Visit/Chief Complaint: ____

Height: ________ Feet ________ Inches Weight: _________ Occupation: _____________________ Shoe Size: ______________

Flu Vaccine: ______ Yes ______ No When? ___________ Pneumonia Vaccine: ______ Yes ______ No When? ___________

Diabetic: ______Yes ______ No Date Diagnosed: ______________ **Type 1** or **Type 2** Last A1c or BGL: ________________

Alcohol Consumption: ______ Yes ______ No If Yes, how often and what type of Alcohol? ________________________________

Tobacco Use: ______ Yes ______ No ______ Quit/Date: __________ If Yes, how many packs per day do you smoke? ___________

Recreational drug use: ______ Yes ______ No ______ Recovering If Yes/Recovering, what drug(s)? _______________________

Living Will or Power of Attorney: ______ Yes ______ No

- Check the box to the right that applies to **YOUR** Medical/Surgical History.

High Blood Pressure		COPD		Gallbladder removed	
Cancer _______________		GERD		Appendectomy	
Arthritis		Multiple Sclerosis		Tonsillectomy	
Stroke		Neuropathy		Hysterectomy? Partial or Total	
Heart Attack		High Cholesterol		Joint replacement? _______________	
PAD		TIA		Arthroscopic surgery? _____________	
HIV/AIDS		Cataract surgery L/R/Bilateral		Skin Cancer removal? _____________	
Hepatitis A/B/C		Numbness or tingling in feet		Foot or Ankle injuries/surgery	
Blood Clot		Wounds? History/Current		Hernia repair	
Gout		Corrective Lenses		Pacemaker	
Atrial Fibrillation		Hearing Aids		Spinal Surgery	
Hypothyroidism		Dentures		Cosmetic surgery	
				Vascular surgery	

- Check the box to the right if it applies to **YOUR FAMILY** (Blood Relatives Only)

Diabetes TYPE I		Stroke	
Diabetes TYPE II		Heart Attack	
High Cholesterol		Coronary artery disease	
High Blood Pressure		Blood Clot	
Alzheimer's Disease		Adopted/No Knowledge	

- Please list all Medications you are currently taking:

MEDICAION NAME	DOSAGE	HOW MANY TIMES A DAY

Medication Allergies

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