

NEW PATIENT
INFORMATION



EAST VALLEY
FOOT & ANKLE
SPECIALISTS

DATE _____

NAME _____ PHONE() _____

AGE _____ BIRTHDATE _____ SS# _____ MALE FEMALE

ADDRESS (local) _____ City _____ State _____ Zip _____

ADDRESS (perm) _____ City _____ State _____ Zip _____

EMPLOYER _____ OCCUPATION _____

WORK PHONE () _____ CELL PHONE _____

FAMILY DOCTOR _____ DATE OF LAST VISIT _____

Family Information

SPOUSE PARENT/GUARDIAN OTHER _____

NAME _____ PHONE# _____ WORK# _____

STREET _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT _____ PHONE# _____

HAS ANY FAMILY MEMBER BEEN TREATED AT THIS CLINIC? YES NO / NAME _____

Who may we thank for referring you? (Please give name)

DOCTOR _____ RELATIVE _____ FRIEND _____

YELLOW PAGES (which one) _____ OTHER (please specify) _____

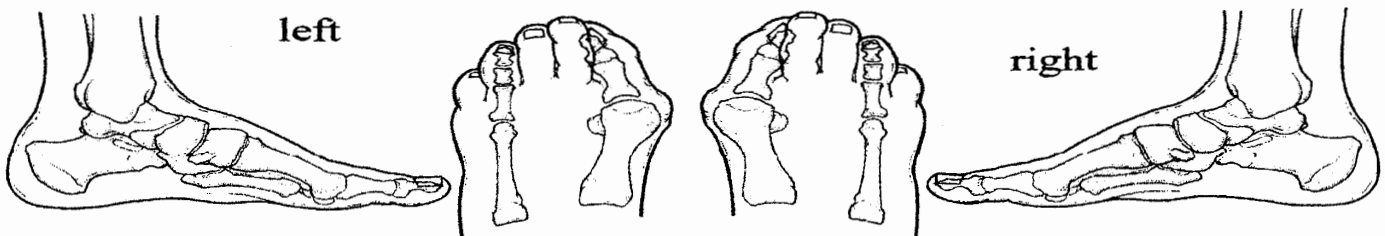
MEDICAL HISTORY (CONTINUED ON OTHER SIDE-PLEASE COMPLETE ALL AREAS)

CHIEF COMPLAINT/REASON FOR COMING TO THE CLINIC:

HOW LONG HAS THIS BEEN A PROBLEM? _____

PRIOR HOME/PROFESSIONAL TREATMENT _____

CIRCLE AREA OF CONCERN:



Physician initials _____

MAJOR ILLNESSES: PLEASE CHECK ALL THAT APPLY

NONE

- | | | |
|--|--|---|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> MURMUR |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> GOUT | <input type="checkbox"/> MUSCLE DISEASE |
| <input type="checkbox"/> ANESTHESIA DIFFICULTIES | <input type="checkbox"/> HEARING DEFICIT | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> ARTHRITIS-type _____ | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> PHLEBITIS |
| <input type="checkbox"/> ARRHYTHMIA | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> PNEUMONIA |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEPATITIS-type _____ | <input type="checkbox"/> PROSTATE DISEASE |
| <input type="checkbox"/> BLEEDING DISORDERS | <input type="checkbox"/> HIATAL HERNIA | <input type="checkbox"/> PSORIASIS |
| <input type="checkbox"/> BLOOD CLOTS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> PVD |
| <input type="checkbox"/> BOWEL DISORDERS | <input type="checkbox"/> HISTORY OF ALCOHOL DEPENDENCY | <input type="checkbox"/> RSD |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> HISTORY OF DRUG DEPENDENCY | <input type="checkbox"/> SHORTNESS OF BREATHE |
| <input type="checkbox"/> CANCER-type _____ | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> SICLECELL ANEMIA |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> IMPLANTS-type _____ | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> CHRONIC PAINS | <input type="checkbox"/> IRRITABLE BOWEL SYNDROME | <input type="checkbox"/> STOMACH PROBLEMS |
| <input type="checkbox"/> CIRCULATION DISORDERS | <input type="checkbox"/> KELOIDS/SCAR FORMATIONS | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> COLOR CHANGES OF SKIN | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> LEG PAIN/CRAMPS | <input type="checkbox"/> ULCERS-type _____ |
| <input type="checkbox"/> DIALYSIS | <input type="checkbox"/> LING DISEASE | <input type="checkbox"/> VARICOSE VEINS |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> MIGRAINE HEADACHES | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> VISION PROBLEMS |
| <input type="checkbox"/> FIBROMYALGIA | | <input type="checkbox"/> OTHER _____ |

PREVIOUS SURGERY:

(TYPE/DATE) _____

HOSPITALIZATIONS/INJURIES:

SOCIAL HISTORY:

Do you Use Tobacco? Y / N Do you Smoke? Y / N How Much? _____ How Many Years? _____ Yrs Quit _____
Do you Drink Alcohol? Y / N Did you Drink? Y / N Estimate # of drinks per day/week/month? _____

FAMILY HISTORY: Any Family Members with Anesthesia Difficulties? Y / N _____

Diabetes? Y / N _____ Foot Problems? Y / N _____

VITAL STATISTICS: Height: _____ Weight: _____ Shoe Size: _____

Do you have any metal in your Eyes/Body? _____ If Yes/Location _____ Claustrophobic? Y / N

Do you have any Stents? _____ If Yes/Type & Location _____

Female Patients: Are you Pregnant? _____ Date of Last Menstrual Cycle _____

ALLERGIES:

NO KNOWN DRUG ALLERGIES

- | REACTION | | REACTION |
|---|--|--|
| <input type="checkbox"/> ASPIRIN _____ | | <input type="checkbox"/> LATEX _____ |
| <input type="checkbox"/> CODEINE _____ | | <input type="checkbox"/> LOCAL ANESTHETICS: _____ |
| <input type="checkbox"/> GENERAL ANESTHETICS _____ | | <input type="checkbox"/> PENICILLIN _____ |
| <input type="checkbox"/> IODINE/SHELLFISH _____ | | <input type="checkbox"/> SULFA DRUGS _____ |
| <input type="checkbox"/> OTHER MEDICATIONS _____ | | <input type="checkbox"/> ENVIRONMENTAL ALLERGIES _____ |
| <input type="checkbox"/> FOOD ALLERGIES _____ | | |
| <input type="checkbox"/> METAL/EARRINGS/JEWELRY ALLERGIES | | |
| <input type="checkbox"/> OTHER: _____ | | |

MEDICATIONS: Please List ALL Prescription and Non-Prescription Medications, Vitamins/Herbs, Supplements and Diet/Weight Gain Products

NONE

Physician initials _____