

Medical Information

Primary Care Physician: _____ Date Last Seen: _____
(Required if you have Medicare)

How were you referred to us? _____

Weight: _____ Height: _____ Shoe size: _____

Last Blood Pressure (if known) _____

If you are a Diabetic: Blood Glucose Range: _____ Hemoglobin A1C _____

What is the reason for your visit? _____

Is this a sports related injury? Yes _____ No _____

If so, what sports do you play? _____

Do you drink alcohol? _____ How many oz per day? _____

Do you smoke? _____ How many packs per day? _____ How many years? _____

Could you be pregnant (if female)? _____

What do you do for exercise? _____

Surgical History:

Previous foot or ankle surgery? Yes _____ No _____

If so, what type of surgery?: _____

Please List Other Surgery: _____

Were there any problems with anesthesia? Yes _____ No _____

If yes, please describe: _____

Signature of patient or legally responsible adult

Date

I hereby consent and give my permission to Drs. Stuart B. Sibel, Lee E. Firestone and Erika M. Schwartz (and the doctor's assistants or designated replacement) to administer and perform treatment of my concerns upon a thorough discussion with the doctor.

Review of Systems (please check yes or no for each)

Yes No

Constitutional

- Chills
- Decreased Appetite
- Fatigue
- Fever
- Night Sweats
- Weight Loss

Eyes

- Blurred Vision
- Double Vision
- Visual Impairment

Ears, Nose, Throat

- Bleeding Gums
- Difficulty Swallowing
- Hearing Loss
- Mouth Sores
- Nose Bleeds
- Ringing in Ears
- Sinus Problems
- Swollen Glands in Neck

Cardiovascular

- Calf Pain When Walking
- Chest Pain
- Irregular Heart Beat
- Night Cramps In Legs
- Palpitation

Respiratory

- Chronic Cough
- Coughing up Blood
- Shortness of Breath
- Snoring
- Wheezing or Asthma

Yes No

Gastrointestinal

- Blood in Stools
- Constipation
- Frequent Diarrhea
- Gastric Ulcer
- Heartburn
- Nausea or Vomiting

Genitourinary

- Blood in Urine
- Frequent Urination
- Incontinence
- Painful Urination

Musculoskeletal

- Back Pain
- Hip Pain
- Joint Stiffness
- Joint Swelling
- Joint Weakness
- Knee Pain
- Muscle pain
- Neck Pain

Integumentary/Skin

- Acne
- Eczema
- Excessive Scaring
- Psoriasis
- Skin Lesions
- Skin Rash
- Slow Healing After Cuts

Yes No

Neurological

- Dizziness
- Headaches
- Numbness hands or feet
- Paralysis
- Seizures
- Tingling hands or feet
- Tremors

Psychiatric

- Anxiety
- Depression
- Difficulty Sleeping
- Forgetfulness
- Panic Attacks
- Victim of Abuse

Endocrine

- Diabetes
- Excessive Thirst
- Excessive Urination
- Heat or Cold Intolerance
- Thyroid Disorder

Hematological/Lymphatic

- Anemia
- Easy Bleeding
- Easy Bruising
- Sickle Cell Disease

Signature of patient or legally responsible adult

Date

Past Medical History: (Please check any illness you have had or presently have)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Lyme's disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Raynauds | <input type="checkbox"/> Gout |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Gastric Reflux |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> COPD | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> DVT | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Cancer (type)_____ |

Other Medical Conditions: _____

Medication Allergies: (Please check all that apply)

- | | | |
|---|----------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Iodine or Contrast Dyes |
| <input type="checkbox"/> Cephalosporins | <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Adhesive tape | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Neoprosin |

Other medication allergies: _____

Current Medications: (Include non-prescription medications, vitamins or supplements)

Name of drug	Dose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

*Please list additional medications on the back of this form if needed.

Preferred Pharmacy

Pharmacy Name: _____

Address: _____

Phone # _____