

Northeast Wisconsin Foot and Ankle Associates - PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth ____/____/____
First M Last

WHAT IS YOUR MAIN FOOT COMPLAINT? _____

Have you ever seen a Podiatrist before? Yes No Please list: Name/Date _____

ALLERGIES

Adhesive/Tape () Aspirin () Codeine () Demerol () Iodine () Local Anesthetics ()
Metals/Jewelry () Latex () Novocain () Peanuts () Penicillin () Seafood () Sulfa ()
Other _____

MEDICATIONS

Please list all your current prescriptions, over-the-counter medications and vitamins _____

Are you taking Coumadin or blood thinners? Yes() No() Oral contraceptives? Yes() No ()

PATIENT HISTORY

Please check all that apply to you AND/OR your family members:

	YOU	FAMILY		YOU	FAMILY		YOU	FAMILY
Acid Reflux	___	___	Cancer	___	___	Malignant Hyperthermia	___	___
Addictions	___	___	AIDS/HIV	___	___	Chemical Dependency	___	___
Liver Disease	___	___						
Allergies to Anesthetics	___	___	Chest Pain	___	___	Low BP	___	___
Allergies/Medicine or Drugs	___	___	Circulatory Problems	___	___	Nervous Problems	___	___
Alzheimers/Dementia	___	___	Diabetes	___	___	Phlebitis	___	___
Anemia	___	___	Epilepsy	___	___	Psychiatric Care	___	___
Angina	___	___	Fainting	___	___	Radiation Treatment	___	___
Arthritis	___	___	Gout	___	___	Raynaud's Disease	___	___
Artificial Heart Valves or Joints	___	___	Heart Disease	___	___	Respiratory Disease	___	___
			Hemophilia	___	___	Rheumatic Fever	___	___
Asthma	___	___	Hepatitis/Jaundice	___	___	Shortness of Breath	___	___
Back Problems	___	___	High Blood Pressure	___	___	Stroke	___	___
Bleeding Disorders	___	___	Kidney Problems	___	___	Tuberculosis	___	___
Blood Clots	___	___	Varicose Veins	___	___	Ulcers	___	___

Are you now, or have you been, under a doctor's care for any reason over the last 2 years? Yes No
If yes please explain _____

PAST SURGERIES

SOCIAL HISTORY

Alcohol Use: Do not drink() Less than 3 /mo() 1-2 drinks /wk() 3-5 drinks /wk() 5 or more /wk()
Do you smoke? Yes() No () If yes, how many years have you smoked? _____

IMMUNIZATIONS

Have you received a tetanus vaccine in the last 10 years? Yes () No ()

Athletic activities in which you participate (please list and indicate frequency) _____

QUALITY MEASURES

SHOE SIZE _____ HEIGHT _____ WEIGHT _____

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

Patient's Signature _____

Date _____