Foot & Ankle Center of Florida LLC

2400 Harbor Blvd. Suite 11 Port Charlotte, FL 33952-5038
P: 941-500-2088 Fax: 941-500-2089
Email: FootAnkleCenterFL@comcast.com

NEW PATIENT HISTORY INTAKE FORM

PATIENT HISTORY INTAKE FORM

Today's Date:

Patient Name:

First:

Last:

Patient Sex:

○ Male ○ Female

○ Transgender change to: ○ Male ○ Female

Marital Status:

○ Single
○ Married
○ Divorced
○ Widowed
○ Separated

Sexual Orientation:

○ Heterosexual
○ Homosexual
○ Bisexual
○ Other

Sexual Activity:

○ Monogamous
○ Polyamorous
○ Swinger

Race:

○ Unreported/refuse to provide
○ Asian
○ Native American/Alaskan Native
○ Pacific Islander/Other
○ Black/African American
○ Hispanic/Latino
○ White/Caucasian (Not Hispanic/Latino)
○ other: Please specify:_____

Languages:

○ Spanish ○ Chinese
○ German ○ Vietnamese
○ French ○ Haitian
○ Italian ○ Russian
○ Korean ○ Arabic
○ Other:_____
○ Brail
○ Sign Language

Ethnicity:

○ Hispanic
○ Not Hispanic or Latino
○ Refuse to Report

Employment History:

○ Employed By:_____
○ Fulltime ○ Part Time
○ Self Employed
○ Not Employed
○ Student. Name of School:_____

Religious Affiliations:

○ Atheist ○ Baptist ○ Catholic ○ Christian ○ Coptic ○ Evangelical ○ Jewish
○ Islamic ○ Methodist ○ Mormon ○ Muslim ○ Presbyterian ○ Scientologist
○ Other: _____

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PATIENT NAME:			Today's Date:
Vitals:	Height:	Weight:	Shoe Size:
Hand Dominance: ○ Right ○ Left ○ Both			
Foot Dominance: ○ Right ○ Left ○ Both			

REVIEW OF SYSTEMS

SYSTEM	○ I have no other symptoms or complaints to report at this time			
General:	○ Fatigue	○ Weight Change	○ Night Sweats	○ Unable to lie flat
Skin:	○ Hair/Nail Changes	○ Rashes / Itching	○ Course Skin	○ Cold Skin
HEENT:	○ Hearing Changes	○ Vision Changes	○ Nose Bleeds	○ Glasses/contacts
Dental:	○ Dentures	○ Bridges	○ Fillings	○ Missing teeth
Respiratory	○ Cough	○ Shortness Breath	○ Wheezing/Asthma	○ Coughing Blood
Breast:	○ Breast Pain	○ Breast Lump	○ Breast Discharge	
Cardiovascular:	○ Angina/pain	○ Heart Trouble	○ Swelling Extremity	○ Murmur / Palpitation
Gastrointestinal:	○ Bowel Problems	○ Pain	○ Rectal Bleeding	○ Nausea/Vomiting
Genitourinary:	○ Blood in Urine	○ Kidney stones	○ Testicle Pain	○ Menstrual Problems
Musculoskeletal:	○ Joint Pain	○ Muscle Cramps	○ Stiffness/swelling	○ Trouble walking
Neurological:	○ Seizures/convulsions	○ headaches	○ Numbness/tingling	○ paralysis/tremors
Psychiatric	○ Confusion/memory loss	○ Bipolar	○ Depression	○ Insomnia
Endocrine:	○ Excessive Thirst	○ Hormone Issues	○ Excess Urination	○ Thyroid Issues
Hematological	○ Abnormal Bleeding	○ Anemia	○ Clotting Issues	○ Bruising
Glands	○ Enlarged			

Past Medical History:	○ I have no other symptoms or complaints to report at this time	
	○ AIDS/HIV	○ Alzheimers
	○ Anemia	○ Arthritis
	○ Arthritis	○ Asthma
	○ Blood Clots	○ Cancer: Type:_____
	○ Congestive Heart Failure	○ COPD
	○ Coronary Artery Disease	○ Depression
	○ Diabetes	○ Abnormal bleeding
	○ Fibromyalgia	○ Hepatitis Type:_____
	○ High Blood Pressure	○ High Cholesterol
	○ Gout	○ Kidney Disease
	○ Liver Disease	○ MI/Heart Attack

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Past Medical History:		
	○ Obesity	○ Osteoporosis
	○ Parkinsons Disease	○ Previous MRSA infection
	○ Psoriasis	○ Pulmonary Embolism
	○ Scoliosis	○ Sleep Apnea
	○ Stroke	○ Thyroid Disease
	○ History of TB	○ Other: Please List:

Allergies:			
	○ I have no medication or food allergies		
	○ Adhesive	○ Ampicillin	○ Anesthesia
	○ Celebrex	○ Dust	○ Eggs
	○ Feathers	○ Iodine/betadine	○ Latex
	○ Lidocaine	○ Mold	○ Morphine
	○ Novacaine	○ NSAIDS	○ Peanuts
	○ Penicillin	○ Pollen	○ Prednisone
	○ Shellfish	○ Sulfadrugs	○ Aspirin
	Other Please List:		

Family History:	○ I have no relevant family history to report. M= Mother F= Father B=Brother S= Sister
	Arthritis ○ M ○ F ○ B ○ S
	Bunions ○ M ○ F ○ B ○ S
	Cancer ○ M ○ F ○ B ○ S
	Coronary Artery Disease ○ M ○ F ○ B ○ S
	Diabetes ○ M ○ F ○ B ○ S
	Flat Feet ○ M ○ F ○ B ○ S
	Hammertoes ○ M ○ F ○ B ○ S
	High Arches ○ M ○ F ○ B ○ S
	High Cholesterol ○ M ○ F ○ B ○ S
	Hypertension ○ M ○ F ○ B ○ S
	Neuropathy ○ M ○ F ○ B ○ S
	Osteoporosis ○ M ○ F ○ B ○ S
	Sickle Cell Disease ○ M ○ F ○ B ○ S
	Other: Please. List: ○ M ○ F ○ B ○ S

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PATIENT NAME:		Today's Date:

Social History:	Alcohol Use: ○ Yes ○ No ○ Quit ○ Former	If Yes then the type used: ○ Wine ○ Beer ○ Hard Liquor Amounts consumed: ○ Socially ○ Daily ○ Weekends ○ 1-2 drinks ○ 3-4 drinks ○ >4 drinks a day
	Tobacco Use: ○ Yes ○ No ○ Quit ○ Former	If Yes then the type used: ○ Cigarette ○ Cigars ○ Pipe ○ Vape/Electronic ○ Hooka Amounts consumed: ○ Socially ○ Daily ○ Weekends ○ 1-2 a day ○ 3-4 a day ○ >4 per day If Former smoker: Last time used:_____
	Drug Use: ○ Yes ○ No ○ Quit ○ Former	If Yes then the type used: ○ Cocaine ○ Crack ○ Marijuana ○ Heroin ○ Crystal Met ○ Ecstasy Amounts consumed: ○ Socially ○ Daily ○ Weekends ○ 1-2 a day ○ 3-4 a day ○ >4 per day Method of deliver: ○ Inravenous ○ Snorted ○ Pill ○ Smoked/Vaped/bonged ○ IM If former user last timed used:_____ Type of Drug previously abused:_____
	Exercise: ○ Yes ○ No	If yes: Frequency of activity: ○ 1x/day ○ 1x/wk ○ 2-3x/wk. ○ 4-5x/wk ○ Weekend only Type of Exercise: _____

Current Medications:

○ I take no medications, supplements or vitamins at this time

Medication/vitamins/supplements	Dosage	Frequency

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PATIENT NAME:		Today's Date:

Surgical History

○ I have no surgeries to report at this time.

Type of Procedure:	Date of Surgery	R=Right L=Left B=bilateral
		○ R ○ L ○ B
		○ R ○ L ○ B
		○ R ○ L ○ B
		○ R ○ L ○ B
		○ R ○ L ○ B
		○ R ○ L ○ B
		○ R ○ L ○ B
		○ R ○ L ○ B

Are you currently under the care of physician?	○ Yes ○ No
If yes, then by whom and what for:	
Is there any chance that you may be pregnant?	○ Yes ○ No
Are you pregnant at this moment in time?	○ Yes ○ No
Do you use any kind of orthotic device/bracing?	○ Yes ○ No
If yes what type of device do you use:	
Do you use an assistive device for walking or getting around?	○ Yes ○ No
If yes what type of device do you use: ○ cane ○ walker ○ quad walker ○ wheel chair ○ scooter	
Do have any difficulty walking/ standing/ loss of balance?	○ Yes ○ No
Have you fallen in the last 12 months?	○ Yes ○ No
If yes, please indicate how often:	
Do you have any type of the vascular problems/conditions?	○ Yes ○ No
If yes, please indicate what kind?	
○ Cold feet/ legs ○ Muscle cramping ○ varicose veins ○ ulcers ○ rashes ○ venous stasis ○ hyperpigmentation	

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Do you use compression stockings?	○ Yes ○ No

PATIENT NAME:		Today's Date:

Do you use lymphedema pumps at home or dressings?	○ Yes ○ No
Have you had any kind of vascular procedure on your legs/feet?	○ Yes ○ No
If yes what kind of procedure; by whom was it performed and when was it done:	
Due your toes turn white/blue?	○ Yes ○ No
Have you ever injured your feet in the past?	○ Yes ○ No
Have you ever injured your legs in the past?	○ Yes ○ No
Can you walk normally without any problems?	○ Yes ○ No

If trouble walking how many blocks can you walk before resting indicate below?

○ less than 1 block ○ 2 blocks ○ 3 blocks ○ 4 blocks. ○ 5 blocks ○ >5 blocks

What is the purpose of your visit? Please explain why we are seeing you today in your own words. If injury occurred at work please state how you were injured, where it occurred, date and time, and who you reported it to.

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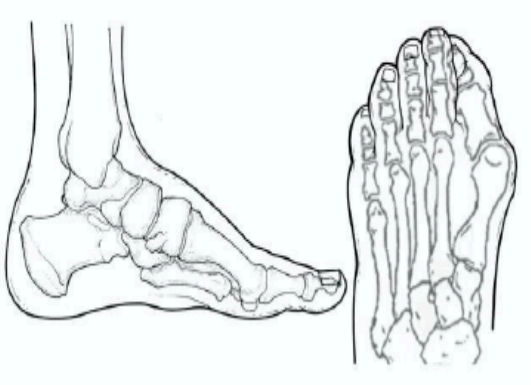
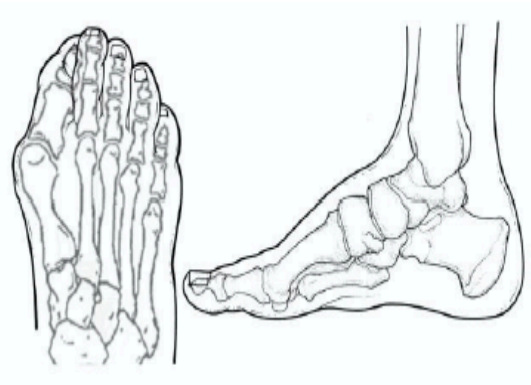
Please mark the picture below where the problem is:



LEFT



RIGHT

PATIENT NAME:		Today's Date:

When does the pain occur?	○ all the time ○ at night ○ in morning ○ at night ○ after activities ○ during activity ○ at rest Other:_____
What makes the pain better?	○ Nothing ○ Elevation ○ Motion ○ Heat ○ Cold ○ Massage ○ Ice ○ Medication ○ Rest ○ Change in foot wear
What makes the pain worse?	○ Nothing ○ Wearing shoes ○ Standing ○ Walking ○ Stairs ○ Physical Activity ○ Sports Activity ○ Work Duties ○ Any Movement ○ Other:_____
Associated Symptoms?	○ None ○ Pain ○ Swelling ○ Limping ○ Shifting weight ○ Other:_____
Have you had any prior treatment for this problem?	○ Yes ○ No By whom?_____
Any previous Diagnostic Tests Performed?	○ None ○ X-ray ○ CT ○ MRI ○ Ultrasound ○Bone Scan ○ Other:_____
Any previous Treatment?	○ None ○ Boot/Brace ○ Cast/Splint ○ Ice ○ Injection ○ Medications ○ Physical Therapy ○ Other:_____
Use of Assistive Device?	○ None ○ cane ○ quad cane ○ Walker ○ Wheelchair ○ Scooter ○ Bracing ○ Orthotics

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	○ Other:_____
Any Previous NSAIDS used?	○ None ○ Aspirin ○ Alleve ○ Ibuprofen ○Other:_____ Duration: Frequency:
Do you have a DNR?	○ Yes ○ No
Do you have a living will?	○ Yes ○ No
Would you like to participate in Foo & Ankle Center of Florida Concierge Plan? The plan is $1500.00/year. ○ Yes ○ No	
PATIENT ATTESTATION	
Patient statement: To the best of my knowledge, the information I will provide is accurate and complete. Under Penalty of Perjury under laws of State of Florida and the Federal Statutes by which we are governed.	
Patient Signature:	Date: