FAMILY FOOT & ANKLE CENTERS OF SOUTH JERSEY
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MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

WHAT FOOT OR ANKLE PROBLEM CURRENTLY CONCERNS YOU? _____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING: (CIRCLE) PAIN BURNING NUMBNESS IN FEET NIGHT CRAMPS

DIFFICULTY WALKING OTHER: _____

IS THERE A FAMILY HISTORY OF FOOT PROBLEMS? _____

HAVE YOU SEEN A PODIATRIST BEFORE? _____ IF SO, WHEN? _____

ARE YOU IN GOOD HEALTH? _____ DO YOU EXERCISE? _____ HOW OFTEN? _____

WHAT TYPE OF EXERCISE DO YOU DO? _____

DO YOU SMOKE? YES NO HOW MUCH? _____ FOR HOW LONG? _____

DO YOU CONSUME ALCOHOL? YES NO HOW MUCH? _____ HOW OFTEN? _____

DO YOU USE /TAKE ILLEGAL DRUGS/NARCOTICS? YES NO HOW MUCH? _____ HOW OFTEN? _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING? POOR VISION POOR HEARING

DO YOU HAVE: LANGUAGE BARRIERS RELIGIOUS/CULTURAL BARRIERS

DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVE? YES NO

HAVE YOU BEEN TOLD THAT YOU HAVE OR HAD ANY OF THE FOLLOWING:

_____ DIABETES	_____ BLOOD CLOTS	_____ STROKE
_____ HIGH BLOOD PRESSURE	_____ KIDNEY DISEASE	_____ CANCER
_____ BLEEDING DISORDERS	_____ HEART DISEASE	_____ STOMACH ULCERS
_____ POOR CIRCULATION	_____ LIVER DISEASE	_____ ARTHRITIS

_____ OTHER _____

WHAT OPERATIONS/SURGERIES INCLUDING FOOT/ANKLE SURGERY HAVE YOU HAD AND WHEN?

_____

_____

_____

I certify that the information above is true and correct to the best of my knowledge. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the Notice.

_____ _____

(Authorized signature) (Date)