Advanced Ankle & Foot Center, LLC

Patient History and Physical Form

Office use only: Chart ID _____

NAME: _____ _____ _____ **SEX**: MALE FEMALE
Last First M.I

BIRTHDATE _____/_____/_____ **SOCIAL SECURITY NUMBER**: _____-_____-_____

ADDRESS: _____ _____
Street Apt #

_____ _____ _____
City State Zip Code

HOME PHONE: ( ) _____-_____**WORK**: ( ) _____-_____**CELL**: ( )_____-_____

RACE: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ White ☐ Other

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline

MARITAL STATUS: _____ **EMAIL**: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

REFERRING PROVIDER: _____ CITY: _____ PHONE:_____

PRIMARY CARE PROVIDER: _____ CITY: _____ PHONE:_____

EMPLOYMENT STATUS: FULL TIME PART TIME NOT EMPLOYED

EMPLOYER: _____ **OCCUPATION**: _____

EMERGENCY CONTACT: NAME _____ **EMERGENCY PHONE**( )_____-_____

YOUR PREFERRED PHARMACY: (PLEASE LIST NAME, LOCATION AND/OR PHONE NUMBER)

_____

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PRIMARY INSURANCE: _____
PRIMARY CARDHOLDER NAME: _____
CARDHOLDER SSN: _____-_____-_____ CARDHOLDER BIRTHDATE: _____/_____/_____

SECONDARY INSURANCE: _____
PRIMARY CARDHOLDER NAME:_____
CARDHOLDER SSN: _____-_____-_____ CARDHOLDER BIRTHDATE: _____/_____/_____

Please Initial: _____ I acknowledge I have received a copy of the Financial Policies form and have access to the form at www.advanklefoot.com

1. What is the reason for your visit today?_____

Location: _____ Severity (1-10): _____

Duration: _____ Associated Symptoms: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE:_____

2. Have you had the flu shot this season? ☐ **Yes** ☐ **No**

3. Are you or do you think you may be pregnant? ☐ **Yes** ☐ **No**

4. MEDICAL HISTORY-Please circle all that apply:

AIDS/HIV	**Blood Disorder**	**Liver Disease**	**Tuberculosis or Exposure**
Anemia	**Cancer**	**Lung Disorder**	**Heart Conditions: _____**
Arthritis	**Congestive Heart Failure**	**Seizure Disorder**	**Infectious Disease: _____**
Asthma	**Diabetes**	**Stroke**	**Stomach Problems: _____**
Blood Clots	**High Blood Pressure**	**Thyroid Disorder**	**Other:_____**

Sleep Apnea-If yes, do you use a CPAP? ☐ Yes ☐No Setting: _____

5. SURGICAL HISTORY: Please list all surgeries _____

_____

6. ALLERGY HISTORY: Do you have any allergies? (Medication or other): ☐ **Yes** ☐**No**

***IF YES, PLEASE LIST:** _____

_____

Have you had any complications with Anesthesia? ☐ **No** ☐ **Yes**_____

7. MEDICATIONS: Please list any medications you are currently taking. Please include over-the-counter medications. (If you have a medication list, we can make a copy).

8. FAMILY HISTORY-Please check all that apply:

	Father	Mother	Brother	Sister	Son	Daughter
Anesthesia Complications						
Bleeding Disorders						
Blood clots						
Cancer						
Diabetes						
Heart Attack or Angina						
Heart Disease						
High Blood Pressure						
Stroke						
Tuberculosis						

9. SOCIAL HISTORY:

Alcohol Use:
- ☐ Non-Drinker
- ☐ Social Drinker
- ☐ Moderate Drinker
- ☐ Heavy Drinker
- ☐Recovering Alcoholic

Smoking Use:
- ☐ Never Smoked
- ☐ Current Smoker
- ☐ Former Smoker

Illicit Drug Use:
- ☐ Never Used
- ☐ Currently Using
- ☐ Previously Used
- ☐ Recovering Drug Addict

Patient/Guardian Signature _____ **Date:** _____

If other than patient, please identify the relationship: _____