ADVANCED FOOT & ANKLE SPECIALISTS

NEW PATIENT/CONSULTATION FORM

Patient Information, Medical History and Lower Extremity Examination

DATE: ___/___/___ Driver's license # _____

NAME: Last _____ First _____ Initial _____

AGE: _____ SEX: ☐ male ☐ female Date of Birth: ___/___/___ Social Security # ___-___-___

Referred By: ☐ Dr. ☐ Mr. ☐ Ms. _____ Personal Physician: _____

Date of Last Visit: ___/___/___

Home Address _____ City _____ Zip _____

Home Phone _____ Employer _____ Occupation _____

Employer Address _____ Telephone _____

Spouse's Name _____ Employer _____

Party Responsible for Account _____

Address (if different) _____

Insurance Company(ies) Name _____

Group Number(s) _____ Policy Number(s) _____

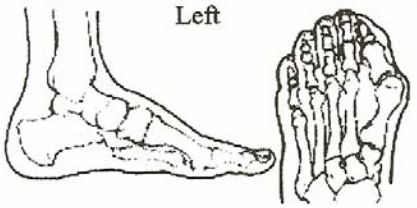
In Case of Emergency, Notify: _____ Telephone _____

Current Problems: (Location, Duration, Onset, Course, Aggravating Factors, Previous Treatment)

Length of time for current problem:

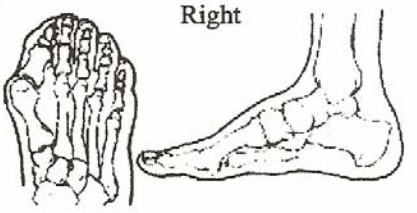
_____ ☐ days ☐ weeks ☐ months ☐ years

Left



Please use circles and arrows to indicate painful, injured or problem area(s)

Right



PATIENT NAME: _____

ACCOUNT NUMBER: _____

PAST MEDICAL HISTORY

Current Medications List:

Are you currently taking any of the following:

☐ Echinacea ☐ Garlic ☐ Ginger ☐ Gingko Biloba ☐ St. John's Wort ☐ Ginseng ☐ Kava kava ☐ Feverfew ☐ Ephedra

Immunization Status:

☐ Polio (OPV or IPV) ☐ DPT/DTaP ☐ Measles ☐ MMR ☐ Hep B (3 doses) ☐ Varicella

Tetanus Status: ☐ Current ☐ Over 5 years ☐ Over 10 years ☐ Unknown

Vital Signs:

(office use)

Height: ___ feet ___ inches Weight: ____ lbs. Resp: ____ Pulse: ____ B.P.: ___/___ Temp: ____ ° F.

Allergies:

☐ Penicillin ☐ Sulfa drugs ☐ Aspirin ☐ Codeine ☐ Iodine/Shellfish ☐ Tape
☐ Local anaesthetics ☐ General anaesthetics ☐ Latex
☐ Other antibiotics ☐ Other pain medications ☐ Non-steroidal medications

Medication allergies: _____

Food allergies: _____

Environmental allergies: _____

Previous Injuries:	Previous Surgeries:	Previous Hospitalizations:

PATIENT NAME: _____

ACCOUNT NUMBER: _____

ILLNESSES

MAJOR DISEASE:
- ❑Diabetes
- ❑Hypertension
- ❑Angina
- ❑Heart Disease
- ❑Heart Attack
- ❑Arrhythmia
- ❑Murmur
- ❑Mitral Valve Prolapse
- ❑Stroke
- ❑Chest Pain

HEENT:
- ❑Headaches
- ❑Eye Problems
- ❑Hearing Problems

RESPIRATORY:
- ❑Asthma
- ❑Bronchitis
- ❑Frequent Colds
- ❑Lung Disease
- ❑Shortness of Breath
- ❑Tuberculosis
- ❑Emphysema

ARTHRITIS:
- ❑Osteoarthritis
- ❑Rheumatoid
- ❑Gout
- ❑Sero-negative: Reiter's, PsA, Anklyosing Spondylitis, CCPD, Irritable Bowel

VASCULAR:
- ❑Anemia
- ❑Sickle Cell
- ❑Bleeding Disorders
- ❑Poor Circulation
- ❑Night Cramps
- ❑Leg Pain When Walking
- ❑Vein Problems
- ❑Spider Veins
- ❑Varicose Veins
- ❑Swelling Phlebitis
- ❑Leg Ulcerations
- ❑Blood Clots
- ❑Transfusions

GASTROINTESTINAL:
- ❑Ulcers
- ❑Stomach Problems
- ❑Hiatal Hernia
- ❑Bowel Disorders
- ❑GI or Rectal Bleeding
- ❑Acid Reflux (GERD)

MISCELLANEOUS:
- ❑Epilepsy
- ❑Thyroid Disease
- ❑Muscle Disease
- ❑Kidney Problems
- ❑Bladder Problems
- ❑Prostate Problems
- ❑Venereal Disease
- ❑Skin Conditions
- ❑Cancer History
- ❑Hepatitis

PSYCHOLOGICAL:
- ❑Anxiety
- ❑Depression
- ❑Psychiatric Conditions
- ❑Drug Dependence
- ❑Alcohol Dependence

OTHER ILLNESSES:

_____

SOCIAL HISTORY:

Occupation: _____

Athletic Activities: _____

☐ Single
☐ Married

Alcohol: _____ oz/day/week

Tobacco: ___pks/d for ___yrs

FAMILY HISTORY: _____

I hereby give my permission to Dr. Y. Bryan Lee to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physician all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account.

Signature of Responsible Party _____ Date ___/___/___