Strash Foot and Ankle Care

PATIENT INFORMATION

Patient's Last Name	First	Middle Initial

Street Address	City	State	Zip Code	Home Phone

Cell Phone	Date of Birth	◯ Male ◯ Female	Social Security Number	Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Patient's Occupation	Patient's Employer	Emergency Contact Name	Emergency Contact Phone Number

Patient's Employer Street Address	City	State	Zip Code	Work Phone

HOW DID YOU HEAR ABOUT OUR OFFICE?

◯ Google	◯ Our Website	◯ Insurance List	◯ Family/Friend	Doctor's Office
◯ Bing	◯ Yahoo	◯ Texas Med	◯ Facebook	Urgent Care Clinic

MEDICAL HISTORY

What foot or ankle concern would you like addressed by your doctor today?

Location of your problem					When did your condition start?	Was it caused by an injury?
◯ Left Fore Foot	◯ Right Fore Foot	◯ Left Midfoot	◯ Left Heel	◯ Left Ankle		◯ Yes ◯ No
		◯ Right Midfoot	◯ Right Heel	◯ Right Ankle		

If yes, how did it happen?

Check the box to indicate your **average** day to day pain level

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Minimal Moderate Severe Intolerable

What makes it worse? ◯ Walking ◯ Running ◯ Uneven Ground ◯ Certain Shoes ◯ Getting up from a seated position

What modifications have you tried? ◯ Medication ◯ Injections ◯ Physical Therapy ◯ Arch Supports ◯ Bracing ◯ Change Shoes ◯ Surgery

Allergies ◯ None ◯ Penicillin ◯ Codeine ◯ Sulfa ◯ Iodine ◯ Anesthetics ◯ Latex ◯ Jewelry

◯ Anti-inflammatories Other:

Medication Name	Dose	Medication Name	Dose	Medication Name	Dose

Recent Surgeries				

Shoe Size	Height	Weight	Do you Smoke? ◯ Yes ◯ No	Packs/day	Do you drink? ◯ Yes ◯ No How Often?

Family Medical History (not you) ◯ Heart Disease ◯ High Blood Pressure ◯ Diabetes ◯ Cancer ◯ Cholesterol ◯ Bleeding Problems

Your Medical History ◯ Diabetes ◯ High Blood Pressure ◯ Thyroid ◯ Heart Disease ◯ Asthma ◯ Bleeding Problems

◯ Pacemaker ◯ Liver Disease ◯ UTI ◯ Blood Clots ◯ Gout ◯ Osteoarthritis ◯ Rheumatoid Arthritis ◯ Seizures

◯ Neuropathy ◯ Anemia ◯ Anxiety ◯ Depression ◯ Osteoporosis ◯ Kidney Disease ◯ Cholesterol ◯ Cancer ◯ HIV

Have you had any of these symptoms in the last 6 months? ◯ Weight Loss ◯ Change in appetite ◯ Leg Cramps ◯ Blurred vision ◯ Eye Glasses

◯ Cataracts ◯ Hearing loss ◯ Headache ◯ Hoarseness ◯ Chest Pain ◯ Palpitations ◯ Heart Attack ◯ Shortness of Breath

◯ Cough ◯ Wheezing ◯ Rashes ◯ Ulcers ◯ Masses ◯ Heat Intolerance ◯ Cold Intolerance

Your Pharmacy	◯ HEB	◯ Walgreens	◯ CVS	◯ Wal-Mart	Other	Corner of?
Family Doctor		Your Email				

I authorize the release of any medical information necessary to process this claim and request payment of benefits, government or other, to be made to: Alamo Family Foot Care, PA. (AFFC)

I Herby give permission to the podiatrists of Alamo Family Foot Care, PA to examine, administer treatment and perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition. I Hereby acknowledge the receipt of the privacy practices (Health Information and Portability Act) of AFFC.

Signature of patient or guardian Date