ROPER ST. FRANCIS
PHYSICIAN PARTNERS

Orthopaedic Surgery

New Patient Intake- Podiatry: Foot & Ankle

Patient Name: _____
DOB: _____ Age: _____ Referred by: _____

Medical/Social History:

Have you ever been diagnosed or treated for any of the following conditions?

Yes____ No____ Alzheimer's/ Dementia Disease
Yes____ No____ Arthritis (Painful/Swollen Joints) What Body Part? _____
Yes____ No____ Rheumatoid Arthritis
Yes____ No____ Osteoporosis
Yes____ No____ Bleeding tendencies with surgery/cuts? Do you take Coumadin? Yes____ No____
Yes____ No____ Cancer? If yes, explain: _____
Yes____ No____ Neurological Problems or Seizures? If yes, explain: _____
Yes____ No____ High Cholesterol
Yes____ No____ Diabetes? If yes, circle one: Food Controlled Tablet Insulin
Yes____ No____ Hypertension, Abnormal Blood Pressure. Circle one: High or Low
Yes____ No____ Kidney Problems? If yes, explain: _____
Yes____ No____ Liver Disease, Hepatitis, Jaundice
Yes____ No____ Neuropathy
Yes____ No____ Poor Circulation
Yes____ No____ Spine Disorders or Back Pain
Yes____ No____ Respiratory Conditions (lung or breathing problems)? If yes, explain: _____
Yes____ No____ Stroke? Date(s): _____
Yes____ No____ Ulcers of leg or foot. If yes, explain: _____
Yes____ No____ Pregnant at present? (Females only)

Are you allergic to any of the following? (Please check all that apply.)

Latex__ Adhesive Tape__ Aspirin__ Codeine__
Lidocaine__ Shellfish__ Novocain__ Percocet__
Sulfa__ Penicillin__ NSAIDS__ Iodine__

Allergies: Please list any additional allergies below.

Medication	Date Noted/Reaction

Family History: Do you have a family history of any of the following? (Please circle all that apply.)

Diabetes: Mother/ Father / Brother / Sister
Cancer: Mother/ Father / Brother / Sister
Stroke: Mother/ Father / Brother / Sister
High Blood Pressure: Mother/ Father / Brother / Sister
Heart Problems: Mother/ Father / Brother / Sister
Poor Circulation: Mother/ Father / Brother / Sister

Do you smoke? YES NO Do you drink? YES NO
If yes, how many packs a day_____ If yes, how much in a week _____
How long have you smoked_____

Surgical History: Please list previous surgeries.

Procedure	MM/YYYY

Medications: Please list any medications you are currently taking including over-the-counter medication.

Medication Name	Dosage

Reason for Today's Visit:

☐ Right Foot ☐ Left Foot ☐ Right Toe ☐ Left Toe Other: _____

Check one of the following:

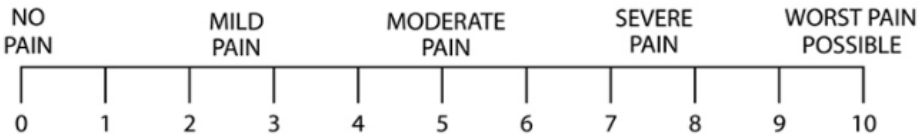
☐ No Injury- estimated date symptoms began: _____

☐ Injury- date of injury: _____

If injury:

Where did the injury occur? ☐ Home ☐ Work ☐ School ☐ Sports ☐ Other: _____

Rate your pain on a scale of 1 to 10. (Circle Number)



Check all symptoms that apply.

Numbness__	Tingling__	Stiffness__	Locking__
Swelling__	Throbbing__	Instability__	Catching__
Weakness__	Popping__	Aching__	Constant__
Sharp pains__	Shooting Pains__	Stabbing Pains__	Dull Pain__
Burning__	Other: _____		

What makes your pain worse? _____

What makes your pain better? _____

Have you had any recent imaging? ☐ YES ☐ NO

If yes, (circle one)

Type of Imaging: X Ray MRI CT

Date Performed: _____ Facility: _____