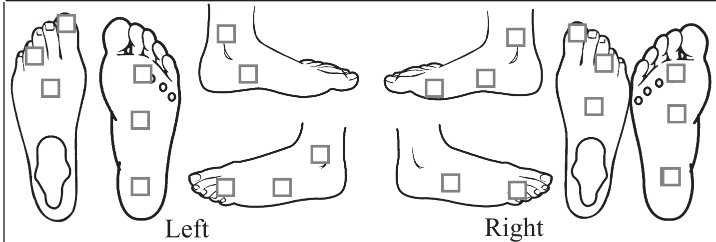
ANKLE & FOOT CENTERS OF GEORGIA - PATIENT INFORMATION

First	Mi	Last	Name Prefer	Occupation	Today's Date
Sex ☐ M ☐ F	Age	Birth Date	Shoe Size	Weight	Height



Please mark the location of your problem(s) or pain **on the diagram** and **number** them(i.e.1,2 ect.) Describe the problem below and the cause if you know.______________

Describe type of symptom and associate # from diagram.

☐ Shooting Pain__________ ☐ Aching pain__________
☐ Throbbing Pain__________ ☐ Tenderness__________
☐ Sharp Pain__________ ☐ Dull pain__________
☐ Burning Pain__________ ☐ Tingling__________
☐ Itching__________ ☐ Numbness__________

When did the symptoms start? ______________

☐ Walking and / or ☐ Running: ☐ Improves condition

☐ Worsens Condition ☐ Doesn't change condition

Shoe Gear: ☐ Improves ☐ worsens ☐ Dosen't Change / Condition

Severity: ☐ Mild ☐ Moderate Severe

The Condition is: ☐ improving ☐ worsening ☐ unchanged

Timing of symptoms:

☐ Early morning pain ☐ Gradual onset
☐ Primarily at night ☐ Sudden
☐ Throughout the day ☐ With Exercise
☐ Toward end of day ☐ Unknown
☐ Other ______________

Previous medical treatment(s) or home remedies:______________

Please list the athletic activities in which you are involved :

Do you now wear or have you previously worn:

Orthotics? ☐ Yes ☐ No Still in use? ☐ Yes ☐ No

What other foot or leg problems do you have?

☐ Left ☐ Right ☐ Both

☐ Ingrown Nails ☐ Warts
☐ Thick yellow nails ☐ Foot Numbness
☐ Corns\callouses ☐ Arch pain
☐ Bunions ☐ Heel Pain
☐ Hammer toes ☐ Ankle Pain
☐ Leg Pain ☐ Other:______________

Medical History: Do you have or have you ever been treated for

☐ Anemia ☐ Gout ☐ Lung Disease
☐ Alzheimer's ☐ Heart Attack ☐ Nerve disorders
☐ Arthritis ☐ Heart Condition ☐ Osteoporosis
☐ Asthma ☐ High Blood Pressure ☐ Phlebitis
☐ Back Pain ☐ HIV +AIDS ☐ Poor Circulation
☐ Bleeding disorders ☐ Hi Cholesterol ☐ Rheumatic Fever
☐ Cancer ☐ Hepatitis ☐ Stroke
☐ Diabetes ☐ 1 or ☐ 2 ☐ Kidney Disease ☐ Stomach Ulcers
☐ Epilepsy ☐ Keloid\Scar ☐ Thyroid Disorder
☐ GERD ☐ Liver Disease ☐ Tuberculosis
☐ Glaucoma ☐ Vascular Disease ☐ None of these

☐ Other ______________

Have you had surgery? ☐ Yes ☐ No

Surgery For & Date ______________

ALLERGIES: Please check the medications that you are allergic to and the type of reaction that you get. ☐ None

☐ Adhesive tape ☐ Novocaine
☐ Aspirin ☐ Pain medications
☐ Codeine_ ☐ Penicillin
☐ Demerol_ ☐ Shrimp, Iodine
☐ Motrin, Advil ☐ Sulfa
☐ Morphine ☐ Other Antibiotics
☐ Others:______________

Medications:

Are you taking Insulin? ☐ Yes ☐ No
Are you taking any other medications? ☐ Yes ☐ No
Medications & Dose: (list or attach)______________

Social History:

Do you smoke now or use tobacco? ☐ Yes ☐ No
Alcoholic beverages? ☐ None ☐ Rarely ☐ Moderately ☐ Daily
Recreational Drugs? ☐ None ☐ Rarely ☐ Moderately ☐ Daily

Family History:

List relationship to you of blood relatives who have had:

Arthritis __________ Foot Problems __________
Birth Defects__________ Heart Attack __________
Cancer __________ High Blood Pressure __________
Diabetes __________ Stroke __________

Current Health:

Do you have joint implants? ☐ Yes ☐ No
Do you have artificial heart valves? ☐ Yes ☐ No
Are you under chemotherapy? ☐ Yes ☐ No
Have you had any other serious illness? ☐ Yes ☐ No
Any abnormal bruising, bleeding or scarring? ☐ Yes ☐ No
Are you slow to heal after cuts? ☐ Yes ☐ No
Other: ______________