Family Foot and Ankle

Sheila Noroozi DPM
Kathleen Telusma DPM
Andrew Franklin DPM

Date: _____ Patient Name: _____ DOB: _____
Current weight: _____ Height: _____ Shoe size: _____
Reason for visit: _____ Date of onset: _____
Primary Care Physician: _____ Date last seen: _____
How did you hear about our office? _____

Medical History (please check all those that apply)

Diabetes Mellitus: __Type 1 __Type 2 __Insulin dependent __Oral Medication __Diet controlled

__Alzheimer's
__Anemia
__Anxiety
__Arthritis
__Asthma
__Atrial Fibrillation
__Autoimmune Disorder
Type: _____
__Back pain
__Bipolar Disorder
__Cancer
Type:
__Circulation problems
__Cerebral Palsy
__Cerebrovascular Accident (CVA)
__Congestive Heart Failure (CHF)
__Coronary Artery Disease
__COPD/Emphysema
__Dementia
__Down Syndrome
__Dropfoot
__Deep Venous Thrombosis (DVT)
__Epilepsy/Seizure Disorder
__Fibromyalgia
__Gastric reflux
__Gastric Ulcers
__Glaucoma
__Gout
__Heart Attack (MI)
__Heart Disease
__Hepatitis
__Herniated Disc
__High Blood Pressure
__High Cholesterol
__HIV/AIDS
__Hyperthyroid
__Hypothyroid
__Irritable Bowel Syndrome
__Kidney Disease
__Dialysis Yes/No
__Liver Disease
__Lupus
__Lymphedema
__Macular Degeneration
__Menopause
__Mitral valve Prolapse
__Multiple Sclerosis
__Osteopenia
__Osteoporosis
__Parkinson's Disease
__Peripheral Neuropathy
__Peripheral Vascular Disease
__Prostate Problems
__Psoriasis
__Psoriatic Arthritis
__Pulmonary Embolism
__Raynaud's Disease
__Rheumatoid Arthritis
__Seasonal Allergies
__Sciatica
__Sickle Cell Disease
__Skin Cancer
Type:
__Sleep Apnea/CPAP
__Spinal Stenosis
__Stroke
__Toenail fungus
__Tuberculosis
__Ulcerative Colitis
__Varicose Veins
__Venous Insufficiency

Please list any condition(s) not listed above: _____
_____
_____

Previous Surgeries:

__Appendectomy
__Cardiac (Heart) Stents
__Carotid Artery (Endarterectomy)
__Cataract
__Coronary (Heart) Angioplasty
__C-Section
__D&C
__Eye Surgery
__Gallbladder
__Hernia Repair
__Hip Replacement
__Hysterectomy
__Heart Bypass (CABG)
__Knee Replacement
__Kidney Surgery
__Leg Bypass
__Leg Stents
__Pacemaker/Defibrillator
__Tonsillectomy
__Transplant type: _____
__Vein surgery/Radioablation

Please list any surgeries not listed above: _____
_____

Previous Foot Surgeries:

__Amputation
__Biopsy
__Bone Spur Removal
__Bunion Correction
__Foot/Ankle Fracture
__Hammertoe Correction
__Heel spur removal
__Toenail sx
__Neuroma removal
__Tendon sx
__Plantar fascial release
__Wart Excision or Laser

Please list any foot surgeries not listed above: _____

Please list all medications you are taking: _____
_____
_____

Family History:

Are you adopted? Yes/No
Mother DOB: _____ Deceased? Yes/No When? _____
Did your mother have any of the following?: __Diabetes __Cancer __Gout __High Blood Pressure
Father DOB: _____ Deceased? Yes/No When? _____
Did your father have any of the following?: __Diabetes __Cancer __Gout __High Blood Pressure

Social History:

Do you drink alcohol? Yes/No How often? _____
Do you do any recreational drugs? Yes/No How often? _____
Do you smoke? Yes/No How often? _____
Did you quit smoking? Yes/No Date you quit: _____
Do you drink __coffee __tea __soda (caffeinated) Yes/No
How often do you exercise? __Daily __Weekly __Never Type of exercise: _____
What do you do for work? _____

Allergies:

Antibiotic Ointment
Aspirin
Adhesive Tape
Ciprofloxacin
Codeine
Cortisone
Iodine/Betadine
Latex
Novocaine
NSAID
Penicillin
Sulfa

Please list any allergies not listed above: _____
What type of reaction did you have? _____