FOOT & ANKLE SPECIALISTS
— OF CENTRAL PA —

Patient Information

Today's Date_____

Name:
First:_____ Middle:_____ Last:_____

Date of Birth:_____ Age:_____ Sex: M F

Marital Status: Single / Married / Divorced / Widowed

Mailing Address:_____

Home Phone#_____Cell Phone#_____

Email Address:_____

Emergency Contact:_____ Phone#_____

Employer:_____ Phone#_____
Employer Address:_____

Insurance : _____ Subscriber:_____
Policy #_____ Group#_____

Family Physician:_____ Phone#_____ Fax#_____
Address:_____

How did you hear about Foot and Ankle Specialist of Central PA: Please Check Below
___ Family ___ Friend ___ Mailer ___ Internet ___ Yellow Pages ___ Other:_____

Medical information

What is the problem you are having with your foot or ankle?
Problem:_____
Onset:_____
Location:_____
Duration:_____
Changes:_____
Prior Treatment:_____

Social History: Check all that apply

_____Tobacco (pkg /day) _____Alcohol _____Substance abuse

Past Medial History: check all that apply

____Arthritis
____Asthma
____Bleeding Disorder
____Blood Clots
____Cancer
____Circulatory Disorder
____Depression
____Diabetes
____Gastric Reflux
____Gout
____Heart Disease
____Hepatitis
____High Cholesterol
____HIV Infection
____Hypertension
____Kidney Disease
____Liver Disease
____Nerve Pain / Injury
____Neuropathy
____Skin Problems
____Stomach Ulcers
____Varicose Veins

Past Surgical History: Please list below (Hospitalizations/Surgeries W/ Dates)

Orthopedic:_____
Nerve:_____
Other:_____
_____
_____
_____
_____
_____
_____
_____

Family History: Check all that apply

____Diabetes
____Hypertension
____Circulatory Disorder
____Problems w/ Anesthesia
____Bleeding Disorders

Allergies: check all that apply

____Novocain
____Penicillin
____Adhesive Tape
____Food
____Anesthetics
____Latex
____Materials
____Drugs
____Local Anesthetics
____Other (describe)_____

Height:_____
Weight:_____
Shoe size:_____
If Diabetic Last A1C:_____

Pharmacy: _____Phone#_____Fax#_____
Address:_____

Medication List		
Name	Reason	Physician