Metropolitan Ankle & Foot Care Specialists

Date:___/___/____

Patient Name:_____ DOB:___/ ___/ ____ Age:____ Sex: M F

Home Address:_____ City:_____ State:_____ Zip:_____

Please select how you prefer to be contacted:
Home Phone: (_____) _____-_____ YES NO
Cell Phone: (_____) _____-_____ YES NO
E-mail:_____ YES NO

Emergency Contact Info:
Name:_____
Phone #:_____
Relationship:_____

Do you have a legal guardian or healthcare power of attorney? [] YES [] NO
Is there a family member you would like for us to share your medical information?
___ YES Name:_____ Relationship:_____
___ NO
Marital Status: Single Married Partnered Separated Divorced Widowed
Employer:_____ Occupation:_____
How much are you on your feet at work? 10% 50% 75% 100%

INSURANCE:
Health Primary:_____ Secondary:_____
Auto:_____ DOA:_____ Claim #:_____
Workman's Comp:_____ DOA:_____ Claim #:_____

YOUR MEDICAL HISTORY:
Referring Doctor:_____ Date Last Seen:_____ Phone #:_____
Primary Care Doctor:_____ Date Last Seen:_____ Phone #:_____
Pharmacy:_____ Location:_____ Phone #:_____

Quality Measures
Height:_____ Weight:_____ Shoe Size:_____
Smoking History: [] Never [] Quit, how long ago?_____ [] Current, how many packs per day?_____
Alcohol Use: [] Never [] Social [] Moderate [] Heavy [] Quit, how long ago?_____

Have you ever had any of the following:

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorders	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusions	Y	N	Liver Disease	Y	N	Stomach	Y	N
Bronchitis/COPD	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

Other Conditions:_____

Family History:_____

Please List All Medications You Are Currently Taking.
(Include all prescription, Over The Counter, and herbal supplements.)

Name	Dose	How often?

Allergies:
[] No Known Medicine Allergies
[] Anesthesia [] Tape [] Latex [] Shellfish [] Iodine
[] Medications:_____
[]Food:_____ []Other:_____

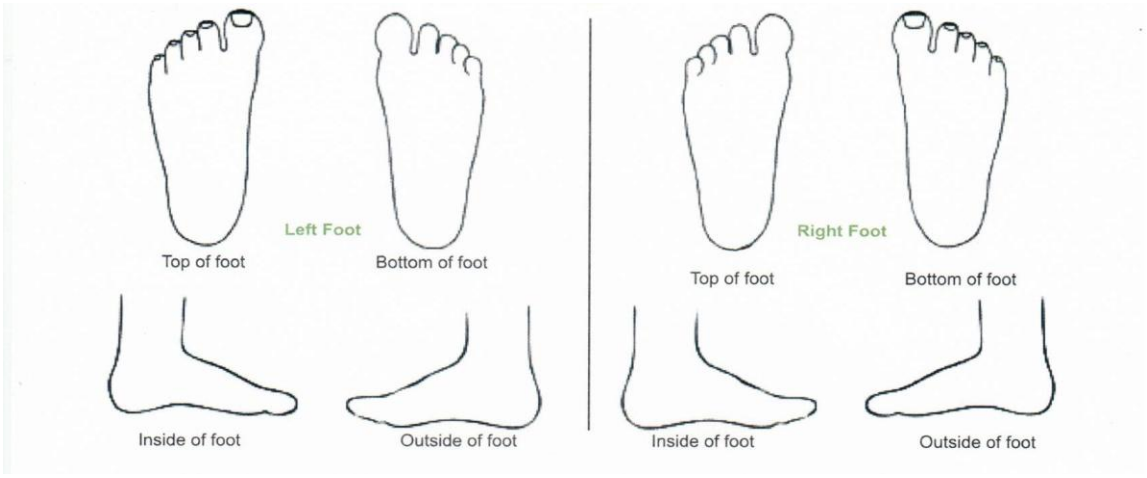
Please List All Prior Surgeries and Hospitalizations.

_____ Date:_____
_____ Date:_____
_____ Date:_____
_____ Date:_____
_____ Date:_____
_____ Date:_____

Current Problems

What specific problem brings you to the office today?_____

Where is the pain/problem located? **Please mark the pictures below.**



How Did You Hear About Our Practice?_____

If by referral, whom may we thank for referring you to the office?_____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes to my medical status.

_____ _____

Print Name of Patient, Parent or Guardian Signature

_____ _____

If Other Than Patient, Relationship to Patient Date

_____

Signature of Doctor

_____

Date