Catoctin Foot and Ankle Center

Patient's Name: **Date of Birth:**

Please Answer All of the Questions: **Shoe size:** _____ **Shoe type:** _____

Chief Complaint: _____

How is your general health? [ ] Excellent [ ] Good [ ] Poor **Height** _____ **Weight** _____

Check all the apply:

[ ] Diabetes	[ ] Tumors	[ ] Cholesterol	[ ] Kidney Pain	[ ] Cancer
[ ] Stroke	[ ] Bleeding Problems	[ ] Anxiety/Depression	[ ] High Blood Pressure	[ ] Blood Clots
[ ] Leg Cramps	[ ] Glaucoma	[ ] Asthma	[ ] Arthritis	[ ] Fibromyalgia
[ ] Epilepsy	[ ] HIV	[ ] Tuberculosis	[ ] Varicose Veins	[ ] Thyroid
[ ] Gout	[ ] Stomach Ulcer	[ ] Polio	[ ] Heart Trouble	[ ] Anemia
[ ] Circulation	[ ] Fainting	Other:		

P**revious Operations or Hospitalizations:** _____

Previous Injuries: _____

Family Medical History (List problems by family members i.e. mother, father, sister, brother, etc.)

Member: _____ Problem(s) _____

Member: _____ Problem(s) _____

Member: _____ Problem(s) _____

Medications (Please include prescriptions, over-the-counter, and herbal supplements)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any allergies? [ ] Yes [ ] No [ ] NKDA *If Yes, please select from the following*

[ ] Aspirin	[ ] Novocaine	[ ] Codeine	[ ] Demerol
[ ] Latex	[ ] Merthiolate	[ ] Iodine	[ ] Adhesive
[ ] Nylon/Plastic	[ ] Antihistamines	[ ] Sulfa	[ ] Penicillin
[ ] Other:			

Smoking Status:

[ ] Current Every day Smoker [ ] Current Some day Smoker [ ] Former Smoker [ ] Never Smoker