Foot & Ankle Center OF IOWA | Bunion Surgery SPECIALISTS

Name:_____DOB:_____SSN:_____
Address:_____City:_____
State:_____ Zip:_____ Birth Gender:_____Gender Identity:_____
Preferred Phone:_____cell home Alternate Phone: _____
Email: _____Marital Status: Single Married Widow Divorced Separated
Employer:_____Job Title:_____
Employer Address:_____
Work Phone:_____Is it OK for us to call you here? Yes No
How did you hear about us?_____

Emergency Contact #1_____Relationship:_____
Phone:_____Alternate Phone:_____
Emergency Contact #2_____Relationship_____
Phone:_____Alternate Phone:_____

Primary Insurance:_____ID:_____
If the insurance is not in your name, please provide the following information:
Subscriber Name:_____Relation:_____DOB:_____
Secondary Insurance_____ID_____
Subscriber Name:_____Relation_____DOB_____

Race/Ethnicity
_____American Indian/Alaska Native _____Latino/Hispanic _____Black/African American
_____Native Hawaiian/Pacific Islander _____Asian _____White
_____Decline to specify
Preferred Language: English Other_____
Is interpretation/translation needed for visits? Please circle one. **YES** **NO**

Is this visit due to an accident or traumatic injury? Yes No
If yes, have you filed or do you plan to file a workman's comp claim? Yes No

If the patient is a minor or is not their own guardian, please provide the information below:
Legal Guardian Name:_____Relation:_____
DOB:_____SSN:_____Phone:_____
Address (if different from above):_____

Signature:_____**Date:**_____
Relationship (if other than patient):_____

PLEASE COMPLETE ALL PARTS OF THIS FORM. IT IS IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL QUESTIONS.

Name_____ Age_____

Date of birth_____ Birth Gender_____

Gender Identity_____

Primary Doctor's Name & Date last seen:_____

_____

Referring Doctor _____

Pharmacy Name & Location _____

_____

Past Medical History: Please "X" any of the following you have or have ever had	
☐ AIDS or HIV	☐ High blood pressure
☐ Alzheimer's	☐ High cholesterol
☐ Anemia	☐ Hormone disorder
☐ **Anesthesia problems**	☐ Immune disorder
☐ Angina	☐ Kidney disease
☐ Arthritis	☐ Kidney failure/insufficiency
☐ Asthma	☐ Kidney stones
☐ **Bleeding disorder**	☐ Liver disease
☐ **Blood clots/DVT**	☐ Neurological disorder
☐ Cancer	☐ Pneumonia
☐ Circulation problem	☐ Prostate disease
☐ Depression	☐ Psoriasis/skin disorder
☐ Diabetes	☐ Psychiatric disorder
☐ Emphysema	☐ Raynaud's syndrome
☐ Eye/vision disorder	☐ Seizures/Epilepsy
☐ Fibromyalgia	☐ Stomach/intestinal bleed
☐ Gallbladder disease	☐ Stroke
☐ GERD/acid reflux	☐ Thyroid disease
☐ Gout	☐ Heart disease
☐ Ulcers: leg/foot	☐ Heart attack
☐ **Healing problems**	☐ Urinary/bladder infections
☐ Other:_____	
☐ Other:_____	

Social History:
Do you drink alcohol? ☐No ☐Yes ☐Beer ☐Wine ☐Liquor
How much? How often?
Do you drink caffeine? ☐No ☐Yes
Type of caffeine:
How much? How often?
Do you take any illegal drugs? ☐No ☐Yes
Occupation:
Do you exercise? ☐No ☐Yes Type of exercise:
How often:
Circle One: Married Single Widowed Divorced
Shoe size: Left_____ Right_____
Do you smoke? ☐No Never ☐Yes
☐Former smoker/year quit _____
How much? How many years?

Medication: Prescribed by doctor or anything you are taking over the counter. (If you have a list, we can take a copy)

NAME	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

ALLERGIES: Drugs & Reactions:
1.
2.
3.
4.
5.
6.

SURGERIES/HOSPITALIZATIONS (Feet & All Others) **MONTH/YEAR**
Ankle ☐No ☐Yes Right/Left
Foot ☐No ☐Yes Right/Left
1.
2.
3.
4.
5.
Review of Systems: Have you experienced any of these symptoms over the last few weeks?
Endocrine: ☐ Cold Intolerance ☐Excessive Thirst
☐ Heat intolerance ☐Sweating
ENT: ☐Bleeding in the throat ☐Congestion ☐Deaf
☐Decreased Hearing ☐Dentures ☐Dry Mouth ☐Ear Ache
☐gum pain ☐hearing aid ☐Hoarseness ☐Itching nose
☐Nasal discharge ☐Nosebleeds ☐Ringing in ears
☐Sore Throat ☐Sore Tongue ☐Stuffy nose
General: ☐ Chills ☐Fatigue ☐Fever ☐Trouble Sleeping
☐Weakness ☐Weight gain ☐Weight Loss
Gastrointestinal: ☐Change in Appetite ☐Constipation
☐Diarrhea ☐Heartburn ☐Nausea
Head/Neck: ☐Blind ☐Blurred Vision ☐Change in Vision
☐Dry eyes ☐Eye strain ☐Glasses/Contacts ☐Head Injury
☐Headache ☐Hoarseness ☐Migraine ☐Neck lumps/mass
☐Neck Pain ☐Neck Stiffness ☐Swollen Glands
Cardiovascular: ☐Chest Pain ☐Palpitations
☐Chest Tightness
Hematologic: ☐Easy bleeding ☐Easy Bruising
Skin: ☐Blister ☐Color Changes ☐Dryness
☐Hair Changes ☐Itching ☐Nail Changes ☐Open wound
☐Rash ☐Skin Changes ☐Skin lesion ☐Skin mass/lump
Musculoskeletal: ☐Ankle Pain ☐Back Pain ☐Foot Pain ☐Heel Pain ☐Hip Pain ☐Joint Pain ☐Joint Stiffness
☐Knee Pain ☐Muscle Pain ☐Redness of Joints
☐Swelling of Joints ☐Toe Pain
Neurologic: ☐Dizziness ☐Fainting ☐Hemiplegia
☐Numbness ☐Paraplegia ☐Seizures
☐Tingling ☐Tremor
Psychiatric: ☐Anxiety ☐Depression
☐Memory Loss ☐Nervousness ☐Stress
Respiratory: ☐Cough ☐Difficulty Breathing
☐Shortness of Breath ☐Sputum ☐Wheezing
Urinary: ☐Blood in Urine ☐Frequency
☐Incontinence ☐Urgency
Vascular: ☐Calf Pain ☐Foot Cramping ☐Leg Cramping
☐Swelling in the feet ☐Swelling in the legs

Family History:

	Mom	Dad	Sister	Brother	Daughter	Son
AIDS /HIV						
Alzheimer's						
Anemia						
Anesthesia problems						
Arthritis						
Asthma						
Bleeding disorder						
Blood clots						
Cancer						
Depression						
Diabetes						
Emphysema						
Eye/vision disorder						
Heart disease						
Heart attack						
High blood pressure						
High cholesterol						
Kidney disease						
Liver disease						
Neurological disorder						
Psychiatric disorder						
Reynaud's syndrome						
Seizures						
Stroke						
Thyroid disease						
Ulcers: foot/leg						

Other:

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles.

SIGNATURE:

DATE:

Name:_____Date of Birth:_____

What is bothering you today?_____

_____

_____

How many months/years has this been going on?_____

How did this happen?_____

Did this happen while you were at work? ◯ No ◯ Yes, Is your employer aware? ◯ No ◯ Yes

Mark the location of the problem(s) with an X

If "0" is no pain or discomfort and "10" is the worst pain or discomfort you ever had, how would you rate your pain or discomfort today? (circle number)

(no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

Is your pain constant? ◯ No ◯ Yes

What have you done to treat it? Orthotic _____ Brace _____ Anti-inflammatory _____

Lotion/cream _____Antibiotic _____ Changed shoe _____ Ice _____Elevation_____

What makes your symptoms worse?_____

Signature: _____Date:_____

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