WELCOME TO OUR OFFICE

**DR. RALPH J. WENTZ**

DIPLOMATE AMERICAN BOARD OF FOOT AND ANKLE SURGERY

**MEDICAL HISTORY:**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_\_Weight:\_\_\_\_\_\_Height:\_\_\_\_\_\_**

**Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_*REASON FOR TODAY’S VISIT:\_\_\_\_\_\_\_\_\_\_***

**Please check if you have or have had any of the following:**

\_\_Diabetes (# of years \_\_\_\_\_) A1c \_\_\_\_ \_\_Heart trouble, Heart Attack, Murmur, Pacemaker

\_\_Numbness of Legs/Feet \_\_Kidney Trouble

\_\_Poor Circulation \_\_Liver Trouble/Hepatitis A-B-C

\_\_Leg Cramping When Walking \_\_Tuberculosis

\_\_Heart Disease \_\_Stomach Ulcers

\_\_Hardening of the Arteries \_\_Asthma/Emphysema/COPD

\_\_Raynaud’s Disease \_\_Anemia

\_\_Varicose Veins \_\_Broken Foot/Ankle Bones

\_\_Phlebitis/Blood Clots \_\_Blood Disease

\_\_Ankle Swelling \_\_Cancer (type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_Lupus/Scleroderma \_\_Epilepsy

\_\_Gout \_\_Osteoarthritis

\_\_High Blood Pressure \_\_Osteopenia / Osteoporosis

\_\_High Cholesterol \_\_ Rheumatoid Arthritis

\_\_Low Thyroid \_\_ In a Risk Group of AIDS

\_\_Stroke \_\_Have AIDS or are HIV Positive

\_\_MRSA \_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Operations: List *ALL* operations you have had:**

Operation: Date:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Medications:**

**List any medicines, steroids, inhalers, or drugs (including aspirin) you are taking now:**

Medication: Dose: When:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Known metal allergies? Yes\_\_\_\_\_ Which metals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_   
Known drug allergies: Are you allergic to any medicines (including iodine, tape or anesthesia)? Yes\_\_\_\_\_\_\_\_No\_\_\_\_\_\_**

Allergy: Type of Reaction:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY: Unknown Adopted \_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Alive (Age) | Death (Age) | Cause | Serious Problem |
| Mother |  |  |  |  |
| Father |  |  |  |  |
| Brothers |  |  |  |  |
|  |  |  |  |  |
| Sisters |  |  |  |  |
|  |  |  |  |  |
| Children |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**SOCIAL HISTORY:**

Your type of work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you retired?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives with you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HABITS:**

Smoking history?\_\_\_Yes\_\_\_\_No How many packs per day?\_\_\_\_\_\_How many years?\_\_\_\_

If stopped smoking, when?\_\_\_\_\_\_\_\_\_\_\_ Marijuana \_\_\_\_Yes \_\_\_\_ No

Alcoholic beverage use:\_\_Yes\_\_No How many drinks per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine use: Do you use caffeine (coffee, tea, soda)?\_\_\_Yes\_\_\_No

Exercise: (Type and frequency)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any problems with: General Anesthesia? \_\_\_Yes \_\_\_No

Excessive bleeding during surgery? \_\_\_Yes\_\_\_No

Slow wound healing after surgery? \_\_\_\_Yes\_\_\_No