

WELCOME TO OUR OFFICE
Wentz Foot and Ankle Specialists

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:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes (# of years _____) A1c _____ | <input type="checkbox"/> Heart trouble, Heart Attack, Murmur, Pacemaker |
| <input type="checkbox"/> Numbness of Legs/Feet | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Liver Trouble/Hepatitis A-B-C |
| <input type="checkbox"/> Leg Cramping When Walking | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Hardening of the Arteries | <input type="checkbox"/> Asthma/Emphysema/COPD |
| <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Broken Foot/Ankle Bones |
| <input type="checkbox"/> Phlebitis/Blood Clots | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Cancer (type _____) |
| <input type="checkbox"/> Lupus/Scleroderma | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteopenia / Osteoporosis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Low Thyroid | <input type="checkbox"/> In a Risk Group of AIDS |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Have AIDS or are HIV Positive |
| <input type="checkbox"/> MRSA | <input type="checkbox"/> 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