MAPLEWOOD PODIATRY member
MIDWEST FOOT & ANKLE SPECIALISTS LLC

NAME____DATE_______________

PRIMARY PHYSICIAN (please fill out completely)
Name____
Address____
____
Phone____
Date last seen___________________________________

BY WHOM WERE YOU REFERRED? (Please circle one)
Phone Book Doctor Patient Other(explain)_______________
Name ____
Address____
____
Phone____

OCCUPATION____
DO YOU HAVE ALLERGIES TO ANY MEDICATIONS/FOODS/LOCAL ANESTHETICS?
(Please include reaction) ____
____
____

CURRENT MEDICATIONS (Please list medications, dosage and reason for taking)

Medication	Dosage	Reason

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS :
(Circle all that apply)

Fatigue	Weight loss	Fever	Nausea	Chills
Poor vision	Hearing loss	Sinus problems	Nose bleeds	Cough
Shortness of breath		Chest pain	Heart murmur	Leg cramps
Heartburn	Abdominal pain	Excessive thirst	Excessive hunger	Urinary problems
Swelling	Joint pain	Numbness	Weakness	Back pain
Bleeding excessively		Skin rashes	Skin lesions	Depression
Nervousness				

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DO YOU OR YOUR FAMILY HAVE A HISTORY OF THE FOLLOWING:
(Please circle **S** for self and **F** for family, then explain)

Diabetes	**S**	**F**	______________________________
Heart problems	**S**	**F**	______________________________
High blood pressure	**S**	**F**	______________________________
Stroke	**S**	**F**	______________________________
Blood clots	**S**	**F**	______________________________
Stomach ulcer	**S**	**F**	______________________________
Hepatitis	**S**	**F**	______________________________
Kidney/Bladder problems	**S**	**F**	______________________________
Liver/Gallbladder problems	**S**	**F**	______________________________
Asthma/Lung problems	**S**	**F**	______________________________
Gout	**S**	**F**	______________________________
Arthritis (type)	**S**	**F**	______________________________
Glaucoma	**S**	**F**	______________________________
Anemia	**S**	**F**	______________________________
Cancer	**S**	**F**	______________________________
Thyroid problems	**S**	**F**	______________________________
Joint replacement	**S**	**F**	______________________________
Psychiatric problems	**S**	**F**	______________________________
HIV positive	**S**	**F**	______________________________
Foot problems	**S**	**F**	______________________________
Other	**S**	**F**	______________________________

LIST ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS INCLUDING DATES:
____
____
____

HEIGHT_________ WEIGHT____________ SHOE SIZE_________________
ARE YOU PREGNANT YES NO

Do you smoke? yes no # of packs per day ______________ when quit ___________
Do you drink? yes no _____ drinks per day ____drinks per week ____drinks per month
Exercise Type______________________________________ Days per week__________________

PLEASE DESCRIBE YOUR CURRENT FOOT/ANKLE PROBLEMS INCLUDING ANY SELF TREATMENT OR TREATMENT BY ANOTHER PHYSICIAN
____
____
____
____