Northeast Wisconsin
Foot & Ankle Associates

PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth ___/____/___
First M Last

GENERAL ALLERGIES ☐ No Allergies

☐ Adhesive/Tape ☐ Local Anesthetics ☐ Metals/Jewelry ☐ Latex ☐ Seafood

DRUG ALLERGIES:_____

MEDICATIONS ☐ No Medications

Please list all your current prescriptions, including over-the-counter medications and vitamins:

_____

_____

PATIENT and FAMILY'S PAST MEDICAL HISTORY

Check all that apply to the patient (P) and/or to family blood relatives Mom (M), Dad (D),Sis (S), Bro (B):

	P	M	D	S	B		P	M	D	S	B		P	M	D	S	B
Acid Reflux						Cancer						Malignant Hyperthermia					
AIDS/HIV						Chemical Dependency						Osteoporosis					
Alzheimer's						Chest Pain						Peripheral Neuropathy					
Anemia						Circulatory Problems						Phlebitis					
Angina						Diabetes						Psychiatric Care					
Anxiety						Epilepsy						Radiation Treatment					
Arthritis						Fainting						Raynaud's Disease					
Artificial Heart Valves						Fibromyalgia						Respiratory Disease					
Artificial Joints						Gout						Rheumatic Fever					
Asthma						Heart Disease						Reflex Sympathetic Dystrophy					
Back Problems						Hepatitis						Shortness of Breath					
Bleeding Disorders						High Blood Pressure						Stroke					
Blood Clots						High Cholesterol						Thyroid					
Bunion						Liver Disease						Tuberculosis					
MRSA (staph infec)						Low Blood Pressure						Ulcers					
						Kidney Disease						Varicose Veins					

LIST PAST SURGERIES ☐ I have had no surgeries.

_____

_____

SOCIAL HISTORY

Alcohol Use: ☐ Do not drink ☐ Less than 3/mo ☐ 1-2 drinks/wk ☐ 3-5 drinks/wk ☐ 5 or more/wk

Do you smoke? ☐ No ☐ Yes If so, for how many years? _____ How many per day? _____

List your current athletic activities (also indicate frequency) _____

_____

SHOE SIZE _____ HEIGHT _____ WEIGHT _____

PREFERRED PHARMACY:_____ _____
Pharmacy Name Location (Street, City)

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.

Patient/Parent Signature _____ **Date** _____