SPACE COAST
Foot & Ankle Center
Specializing in Medicine & Surgery of the Foot & Ankle

Welcome to our office! This information is important for our records and your treatment plan. **Please fill out completely.**

Name:_____**Age:**_____ **Sex (M) (F) Date:**_____

Are you diabetic? (Circle) YES NO If yes, for how long? _____ **Treating Physician:**_____
If yes, are you treated with: (Circle) Insulin Pills Diet

What is your main foot problem today?_____
_____

Where is your pain or problem located? _____

How severe is the pain or problem? (Circle) None Minimal Moderate Severe Other:_____

How long have you had this problem: (Circle) 1 2 3 4 5 6 7 8 9_____**(Circle) Days Weeks Months Years**

When is the problem the worse? (Circle) First out of bed AM PM During/after work Other:_____

How would you describe this pain? (Circle) Shooting Burning Aching Throbbing Bruised Sharp Dull Itching Numbness Tenderness Other:_____

What makes the pain better?_____

What caused the problem or makes it worse?_____

How has it been treated? (Circle) Ice Rest Pads Advil Tylenol Other:_____

Allergies: (Circle) No Known Allergies Penicillin Sulfa Aspirin Tape Codeine Iodine Novocain Epinephrine
List other allergies:_____

List all medications:_____

List all major illnesses:_____

List all surgeries or hospitalizations:_____
_____

Do you have a family history of: (Circle) Diabetes Arthritis Sickle Cell Foot problems Heart or Lung problems Cancer Keloid Scars Other:_____

Social History: Are you (Circle) Single Married Divorced Widowed Other:_____
Do you smoke? (Circle) YES NO If yes, how much per day?_____
Do you drink alcoholic beverages? (Circle) YES NO If yes, how much per week?_____
Do you exercise regularly? (Circle) YES NO If yes, what type of exercise?_____

For Women: Are you, or could you be pregnant? (Circle) YES NO If yes, # of months?_____

Signature_____**Date**_____