SOUTH TEXAS FOOT SPECIALIST

Patient Information	Last: First: MI:			Date:
	SS#:	DOB:	Gender: ◯ M ◯ F	Preferred Name:
Address	Street: City: State: Zip:			
Phone & Email	Phone Number: Email:			
Race	◯ Decline ◯ Black or African American ◯ Asian ◯ American Indian or Alaskan Native ◯ White ◯ Other (please specify) ____			
Language	◯ English ◯ Spanish ◯ French ◯ Arabic ◯ Decline ◯ Other (please specify)______________________			
Ethnicity	◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Unknown ◯ Decline to Specify			
Referring Doctor	Last Name: First Name:			
PCP	Last Name: First Name:			
How did you hear about SFTS?	◯ Friend or Family ◯ Internet ◯ Insurance ◯ Facebook ◯ Returning patient ◯ Magazine ◯ Yelp ◯ Other:_______________________			
Pharmacy Information	Name of Pharmacy: Phones #: ( ) Address or Street Name: City:			
Vitals	Height:__________inches Weight: ___________ lbs. Shoe Size: __________ Hand Dominance: ◯ Right ◯ Left ◯ Both			

Review of Systems	**Please check all that apply OR check No Symptoms**				
General:	◯ Fever	◯ Chills	◯ Recent Weight Change		◯ **No Symptoms**
Skin:	◯ Skin Changes	◯ Nail Change	◯ Rashes		◯ **No Symptoms**
HEENT:	◯ Hearing Loss	◯ Blurred Vision	◯ Unsteady Balance		◯ **No Symptoms**
Respiratory:	◯ Asthma	◯ Difficulty Breathing	◯ Shortness of breath		◯ **No Symptoms**
Cardiovascular:	◯ Chest Pain	◯ Murmur	◯ Swelling (Edema)		◯ **No Symptoms**
Gastrointestinal:	◯ Nausea/Vomiting	◯ Liver Disease	◯ GI Ulcer		◯ **No Symptoms**
Genitourinary:	◯ Blood in Urine	◯ Painful Urination	◯ Kidney Disease		◯ **No Symptoms**
Musculoskeletal:	◯ Joint Pain/Swelling	◯ Joint Stiffness	◯ Pain with 1st Step	◯ Back Pain	◯ **No Symptoms**
Neurological:	◯ Seizures	◯ Numbness	◯ Tingling		◯ **No Symptoms**
Psychiatric:	◯ Anxiety	◯ Depression			◯ **No Symptoms**
Endocrine:	◯ Excessive Thirst	◯ Excessive Hunger	◯ Weight Gain		◯ **No Symptoms**
Hematology:	◯ Blood Clots	◯ Anemia	◯ Calf Pain		◯ **No Symptoms**

Patient Name	

Past Medical History — Please Check all that apply

◯ **I have NO Relevant medical history** *Special Orthopaedic Alert

◯*AIDS/HIV	◯ COPD/Emphysema	◯ *Heart Valve	◯ MI/Heart Attack	◯ Scoliosis
◯ Anemia	◯ Coronary Artery Disease	◯ *Hepatitis	◯ Obesity (BMI > 30)	◯ Seizures
◯ Arthritis:________________	◯ Depression	◯ High Blood Pressure	◯ Osteoporosis	◯ *Sleep Apnea
◯ Asthma	◯*Diabetes Type 1 Type 2	◯ High Cholesterol	◯ Parkinson's	◯ Stroke
◯ *Blood Clot	◯ Excessive Bleeding	◯ Gout	◯ *Previous MRSA	◯ Thyroid Disease
◯ Congestive Heart Failure	◯ Fibromyalgia	◯ *Kidney Disease	◯ Psoriasis	◯ Vascular Disease
◯ Cancer, Type: ____________________		◯ *Liver Disease	◯ *Pulmonary Embolism	

◯ Other: ____

Allergies

◯ **I have NO Medication Allergies / Food Allergies**

A = Allergic Reaction (hives, rash, itching, swelling of mouth / lips) **SE = Side Effect** (headache, nausea, vomiting, diarrhea, constipation, etc.)

◯ Adhesive **A** or **SE**	◯ Codeine **A** or **SE**	◯ Keflex **A** or **SE**	◯ Novocain **A** or **SE**	◯ Pollen **A** or **SE**
◯ Ampicillin **A** or **SE**	◯ DepoMedrol **A** or **SE**	◯ LATEX **A** or **SE**	◯ NSAIDs **A** or **SE**	◯ Prednisone **A** or **SE**
◯ Anesthesia **A** or **SE**	◯ Hydrocodone **A** or **SE**	◯ Meloxicam **A** or **SE**	◯ Peanut **A** or **SE**	◯ Shellfish **A** or **SE**
◯ Celebrex **A** or **SE**	◯ Iodine **A** or **SE**	◯ Morphine **A** or **SE**	◯ Penicillin **A** or **SE**	◯ Sulfa Drug **A** or **SE**

◯ Other: ____________________________ **List Allergic Reaction / Side Effect(s):**____________________________

Family History

◯ **I have NO relevant family history** **M = Mother F = Father B = Brother S = Sister**

Arthritis	◯ M ◯ F ◯ B ◯ S	Hypertension	◯ M ◯ F ◯ B ◯ S
Cancer	◯ M ◯ F ◯ B ◯ S	**Malignant Hyperthermia**	◯ M ◯ F ◯ B ◯ S
Coronary Artery Disease	◯ M ◯ F ◯ B ◯ S	**Blood Clots**	◯ M ◯ F ◯ B ◯ S
Diabetes	◯ M ◯ F ◯ B ◯ S	Sickle Cell Disease	◯ M ◯ F ◯ B ◯ S
Flat Feet	◯ M ◯ F ◯ B ◯ S	Other:_______________	◯ M ◯ F ◯ B ◯ S
Gout	◯ M ◯ F ◯ B ◯ S	* **Alive**	◯ M ◯ F ◯ B ◯ S
High Cholesterol	◯ M ◯ F ◯ B ◯ S	* **Deceased**	◯ M ◯ F ◯ B ◯ S

Social History

Alcohol Use:	◯ Rare	◯ Occasionally	◯ Weekly	◯ Daily	◯ Weekends	◯ No alcohol Use
Tobacco Use:	◯ Never	◯ Some Days	◯ Every Day	◯ Former	◯ Chew	◯ Type_____________
Caffeine Use:	◯ Never	◯ Coffee	◯ Tea	◯ Soft Drink	◯1 cup/day	◯ 2 cups/day
Recreational Drug Use:	◯ Never	◯ Recent quit	◯ Socially	◯ Daily	◯ Type ________________________	
Exercise:	◯ Inactive	◯ Sporadically	◯ Weekly	◯ Twice Weekly	◯ Three Times Weekly	◯ Daily
Martial Status:	◯ Single	◯ Married	◯ Separated	◯ Divorced	◯ Widowed	◯ Partnership

Occupation:____

Patient Name:

Current Medications	◯ **I do NOT take any medications.**		
	Medication / Vitamin / Supplement Name:	Dosage:	Times per day:
Please list all prescriptions, over-the-counter, birth control, blood thinners, vitamins and supplements			

Surgical History Hospitalizations	◯ **I have NO Relevant surgical history**		◯ **I have NOT been Hospitalized**	
	Have you ever had problems with anesthesia? ◯ Yes ◯ No		R = Right L = Left B = Bilateral (both)	
	Name of Surgery, Date	Side	Reason for Hospitalization, Date	Side
		◯ R ◯ L ◯ B		◯ R ◯ L ◯ B
		◯ R ◯ L ◯ B		◯ R ◯ L ◯ B
		◯ R ◯ L ◯ B		◯ R ◯ L ◯ B

Do you think your problem may be affected by weight? ◯ Yes ◯ No

Are you interested in achieving a healthier weight? ◯ Yes (answer next) ◯ No (skip next)

I am interested in structured weight loss and health coaching at Profile*. ◯ Yes ◯ Tell me more
* Profile by Sanford is our preferred wellness partner.

FEMALES: Are you or might you be pregnant? ◯ Yes ◯ No

What are we seeing you for today? ◯ Right ◯ Left ◯ Bilateral (Both) Body Part: ________________________________

How did it start: ◯ Gradual ◯ Suddenly **WITHOUT** injury or trauma ◯ Suddenly **WITH** injury or trauma

Date problem/injury began? ____

Describe injury ____

Course of symptoms? ◯ Worsening ◯ Improving ◯ Staying the same

What is the severity? ◯ Mild ◯ Mild to Moderate ◯ Moderate ◯ Moderate to Severe ◯ Severe

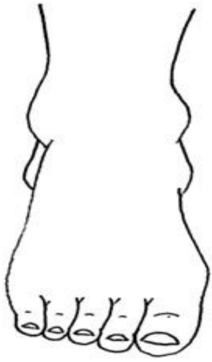
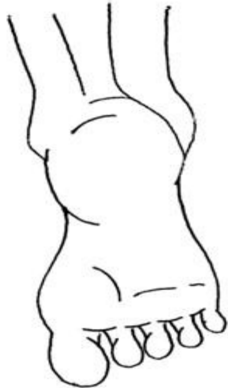
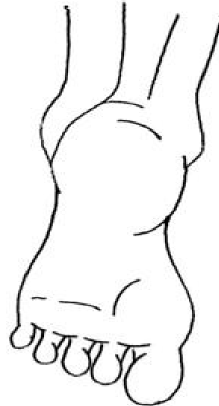
How would you rate your pain? None 0 1 2 3 4 5 6 7 8 9 10 Severe

Described your pain: ◯ Aching ◯ Burning ◯ Dull ◯ Pressure-like ◯ Sharp ◯ Shooting ◯ Throbbing ◯ Tingling ◯ Other: ___________________

How would you describe the extent of your pain? ◯ Localized ◯ Radiates ◯ Diffuse ◯ Constant ◯ Intermittent

Patient Name:

Mark location of symptoms, include severity (0-10):

RIGHT **LEFT**

When do you have pain?	◯ All the time	◯ At night	◯ In the Morning	◯ At Rest
	◯ After Activities	◯ During Activities		
◯ Other: ____				
What makes your pain worse?	◯ Wearing shoes	◯ Standing/Walking	◯ Physical Activity	◯ Any Movements
	◯ Sports Activities	◯ With First Step	◯ Stairs	◯ Other: ____
What makes your pain better?	◯ Nothing	◯ Elevation	◯ Motion	◯ Medication
	◯ Heat	◯ Ice	◯ Rest	◯ Other: ____
Associated symptoms?	◯ None	◯ Swelling	◯ Limping	◯ Opposite side pain from Compensating
Have you had prior treatment?	◯ Yes ◯ No	If yes, by whom? ____		
Previous Diagnostic Test?	◯ None	◯ X-ray	◯ MRI	◯ CT
	◯ Bone Scan	◯ EMG - Nerve Study	◯ Ultrasound	◯ Other: ____
Previous Treatment?	◯ None	◯ Boot / Brace	◯ Cast / Splint	◯ Ice
	◯ Injection	◯ Medication	◯ Physical Therapy	◯ Other: ____
Use of Assistive Devices?	◯ None	◯ Cane	◯ Crutches	◯ Walker
	◯ Wheelchair	◯ Bracing	◯ Orthotics	◯ Other: ____
Previous NSAID use & duration?	◯ None ◯ Aspirin	◯ Aleve ◯ Ibuprofen	◯ Other: ____	Duration: ____

Patient Statement: To the best of my knowledge, the information provided is accurate and complete.

Signature: ____ **Print Name:** ____ Date: ____