Today's Date _____

PLEASE COMPLETE ALL SECTIONS

Patient Details

Patient Name _____

☐ Male ☐ Female Date of Birth_____Age _____

Address_____

City/State _____Zip_____

Phone 1 _____☐ home ☐ cell ☐

work Phone 2_____☐ home ☐ cell ☐

work Email _____

Occupation _____

How did you hear about us? _____

Responsible Party/Billing Contact *(if different from above)*

Name _____

Date of Birth_____Social Security #_____

Address_____

City/State _____Zip_____

Phone _____☐ home ☐ cell ☐ ork

Please describe the reason for today's visit:

How long has it been bothering you?_____

Have you been treated for this problem? ☐ Yes ☐ No
If yes, please describe treatment:

Have you had any previous foot or ankle surgery? ☐ Yes ☐ No
If yes, please list type and dates:

In Case of Emergency, Please Contact:

Name_____

Relationship_____

Phone_____

Primary Care Physician:

Name_____

Phone_____

Date of Last Visit_____

Preferred Pharmacy & Location:

Primary Language: _____

CHECK ALL THAT APPLY:
☐ Hispanic ☐ Non-Hispanic
☐ White
☐ Black or African American
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

PLEASE COMPLETE ALL SECTIONS.
If you have any of the following information already printed, we will be happy to make a copy.

Patient Name:_____ **Date**_____

Current Height_____ **Current Weight**_____ **Current Shoe Size**_____

Allergies

Have you experienced any allergic reactions or adverse effects from the following?

☐ **NO KNOWN DRUG ALLERGIES**

☐ Aspirin ☐ Penicillin
☐ Codeine ☐ Cortisone
☐ Iodine/Betadine ☐ Novocain/Lidocaine
☐ Sulfa Drugs ☐ Latex ☐ Tape

Other:

Medical & Family History

Please check if either ***you or a family member*** has experienced any of the following conditions:

MOTHER	FATHER	PATIENT	
		☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Bleeding Disorder
☐	☐	☐	Breathing Problems
☐	☐	☐	Cancer- type:
☐	☐	☐	Congestive Heart Failure
☐	☐	☐	
		☐	COVID-19 *date:*
☐	☐	☐	Diabetes - Insulin Dependent
☐	☐	☐	Diabetes - Non-Insulin Dependent
☐	☐	☐	Gout
☐	☐	☐	Heart Disease
		☐	Hepatitis
☐	☐	☐	High Cholesterol
☐	☐	☐	High Blood Pressure
		☐	HIV
			Joint Replacement: Hip (☐ Right ☐ Left) Knee (☐ Right ☐ Left)
☐	☐	☐	Kidney Disease
☐	☐	☐	Liver Disease
☐	☐	☐	Mitral Valve Prolapse
☐	☐	☐	Neuropathy
☐	☐	☐	Phlebitis (blood clots)
☐	☐	☐	Stomach Problems
☐	☐	☐	Thyroid Disorder
☐	☐	☐	Other:
☐	☐	☐	Other:

Social History

Do you smoke? ☐ No
☐ Yes, every day ☐ Yes, occasionally
If Yes, how many years?_____
☐ I **previously smoked** for _____years
When did you quit?_____
Do you drink alcohol? ☐ No
☐ Occasional/social ☐ Mild ☐ Moderate ☐ Heavy

Medications

List all prescription medications as well as over the counter medications, vitamins & dietary supplements:

_____ If available, I authorize Infinity Foot and Ankle to obtain
(INITIAL) my current medication list from my pharmacy.

Surgical History

Please list any major surgeries: