

Foot and Ankle Associates of North Texas

PAST HISTORY —FAMILY HISTORY—SOCIAL HISTORY

Last Name: _____ Legal First Name: _____ MI: _____ DOB: _____

Allergies —check mark NONE if the allergies below do NOT apply to you

- None** Adhesive/tape Anesthetics, local Asprin Blood thinners Codeine Dairy Eggs
 Demerol IV contrast dye Iodine Latex Oak Penicillin Seafood Sulfa Other: _____

Previous Foot Procedures

- None** **Month/Day/Year**
 Amputation _____
 Bunion _____
 Hammer Toe _____
 Ingrown Nail _____
 Neuroma _____
 Orthotics _____

Previous Surgeries

- Angioplasty/stent Gallbladder surgery Lap band
 Appendectomy Gastric bypass surgery Lower extremity bypass
 Back/spine surgery Heart bypass surgery Pacemaker
 Blood transfusion Heart valve replacement Tonsilectomy
 Cesarean section Hysterectomy Transplant: _____
 Defibrillator Joint Rplcmnt: _____ Other: _____

Past Medical History—mark NONE if the history below does NOT apply to you

- None** Cancer Gout Lung disease Seizure disorders
 Anxiety Chemotherapy Heart attack Lupus Sports related injury
 Arthritis Circulation problems Heart disease Neuropathy Stomach ulcers
 Asthma Depression Hepatitis-Type: _____ MRSA Infection Stroke
 Bleeding disorder Diabetes High blood pressure Osteoporosis Swelling in legs/feet
 Blood clots Fibromyalgia Kidney disease Pain in legs/feet/toes Thyroid disorders
 Callus formation Foot ulceration(s) Liver disease RSD/CRPS Other _____

Family History

<u>Biological Family</u>	<u>Mother</u>	<u>Father</u>	<u>Sister</u>	<u>Brother</u>	<u>Grandparents</u>
Alive and Well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown/None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

- Live with:** Aunt Children Friends Grandparents No one Parents Pets Partner
 Room-mate Sibling(s) Spouse Uncle
Live in a: Single story home Multilevel home
 Hospice Skilled nursing facility
Occupation: _____
 Position requirements: Climb stairs Lift+ 10 lbs
 Sit Stand Travel Walk Not employed

Activities/Hobbies:

- None
 Aerobics Bowling Cycling Dancing
 Hiking Golf Gymnastics Running
 Soccer Swimming Tennis Walking
 Yoga Other: _____

Caffeine History:

- None
 Less than 7 cups per week
 More than 7 cups per week
 Quit using caffeine

Alcohol History:

- None
 Less than 7 drinks per week
 More than 7 drinks per week
 Quit using alcohol

Smoking History:

- Never a smoker Former smoker Unknown if ever
 Current everyday smoker Current social smoker Current status unknown
 < 1 pack a day 1 pack a day 2 packs a day > 2 packs a day
 Number of years as a smoker: _____

Recreational Drug History:

- Never used recreational drugs
 Have used recreational drugs
 Currently use recreational drugs
 Been treated for substance abuse

Print Name of Patient or Legal Authorized Representative

Signature

Relationship to Patient

Date