Family Foot Specialists, Steven P. Brancheau, D.P.M, David D. Minchey, D.P.M., Lesley Richey-Smith

Name: _____Age: _____ Diabetic (Please Circle) Yes No Date: _____
Are You Pregnant (please circle) Yes No
Current Foot Problems _____
Was this an accident ___ Yes ___ No, if yes, was it on the job accident? ___ Yes ___ No
Date of Accident _____ (If you answered yes, please inform the receptionist immediately.)
Has your employer been informed? ___ Yes ___ No
Description of Pain_____
How long have you had the pain/problem? _____ Where on foot/ankle? _____
Cause by_____ Aggravated By_____
Relieved By_____ Prior Treatment _____ Yes _____ No If yes, what type of treatment and by whom? _____
Primary Care Doctors Is:_____
When was the last time you saw your Primary Care Provider: _____

Past Medical History:
CHILDHOOD: Unremarkable. Rheumatic Fever, Polio, Cerebral Palsy, Bleeding Disorders, Musculoskeletal Disorders, Diabetes
ADULT: Unremarkable. High Blood Pressure, Chest Pain, Shortness of Breath, Heart Disease, Circulatory Disorders (Phlebitis, Claudication, Bleeding Disorders), Diabetes, Gout, Arthritis, Seizures, Lung Problems (Asthma, Emphysema, Bronchitis), Kidney Disorders, Liver Problems (Hepatitis), HIV, Ulcers, Thyroid Problems, Stroke, Cancer, Epilepsy, Tuberculosis, Chemical Dependency, Ankle Swelling.
FAMILY: Hypertension, Coronary Artery Disease, Diabetes, Gout, Asthma, Emphysema, Arthritis, Glaucoma, Stroke, Cancer, Epilepsy/Convulsions, Bleeding Disorders, Kidney Disease, Thyroid Disease, Mental Illness, Osteoporosis, Birth Defects, TB, Alcoholism, Sickle Cell.

Past Surgical History:
Please List Previous Surgeries and Date: _____
_____
Complications: _____
Hospitalized (other than surgeries):_____

Social History:
Single. Married (__ Years). Widowed. Separated. Divorced. ____ Healthy Children ____ Deceased Children
Live with: Spouse. Family. Nursing Home. Assisted Living. Alone.
Number of siblings:_____
Occupation: _____
Tobacco Use: Smoker. Smokes ____ Packs A Day. Smokeless Tobacco. Non-Smoker. Quit ___ Years Ago. Smoked ____ Years. Illicit Drug Use.
Exercise includes: None. Walking Every Day. Walking Occasionally. Jogging. Aerobic Activity ___ Times Per Week. Treadmill. Weight Lifting. Other _____
Caffeine: ___ Yes ___ No Alcohol: ___Yes ___ No If Yes, Daily or Occasionally.
Diet: ___ Yes ___ No If Yes, Why _____
Sleep Habits: Unremarkable. Patient has: Trouble Falling Asleep, Trouble Staying Asleep, Frequent Nighttime Urination, Daytime Drowsiness, Nightmares, and Restless Legs.
Height_____ Weight_____ Shoe Size _____

Current Medications and Doses (If Known) Pharmacy_____ Phone_____

1 _____ 4 _____ 7 _____
2 _____ 5 _____ 8 _____
3 _____ 6 _____ 9 _____

Allergic To (Circle): Penicillin, Sulfa Drugs, Aspirin, Codeine, Iodine, Tape, Cortisone, Local Anesthesia, General Anesthesia, Other _____

Date: