Foot and Ankle Clinic of Spokane

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

Biological Family	Mother	Father	Sister	Brother	Grandparents
Alive and Well	□	□	□	□	□
Deceased	□	□	□	□	□
Cancer	□	□	□	□	□
Diabetic	□	□	□	□	□
Hypertension	□	□	□	□	□
Unknown/None	□	□	□	□	□

Social History

Live with: □ Aunt □ Children □ Friends □ Grand-parents □ 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