RAPPAHANNOCK FOOT & ANKLE SPECIALISTS

Welcome to Our Practice

Please fill out ALL information found below to the best of your ability as it is vital for our records and your treatment..

Patient Name_____ Age:_____ Date_____
Who Referred You _____

History of Present Illness:

Problem:_____
Location:_____
(Where is the pain/problem?)
Severity:_____
(How severe is the pain/problem on a scale of 0-10 with 10 being the most severe?)
Duration:_____
(How long have you had this pain/problem, or when did it start? **If an accident/injury, date of accident needed**.)
Timing:_____
(Does this pain/problem occur at a specific time?)
Symptoms:_____
(Does anything improve the pain?)

Patient Medical History:
Circle if you have ever been treated for any of the following:

Acid Reflux/GERD	Diabetes x _____ yrs	Hyperthyroidism
AIDS or HIV+ (please circle which one)	Epilepsy	Hypothyroidism
Anemia /Blood/Plasma Transfusion	GI Ulcer	Kidney Disease
Anxiety/Depression	Glaucoma	Migraine Headaches
Arthritis - type: _____	Gout	Mitral Valve Prolapse
Asthma	Heart Disease	Pneumonia
Back Trouble	Hepatitis A , B or C	Rheumatic Fever
Bladder Infections	High Blood Pressure	Stroke
Bronchitis	High Cholesterol	Tuberculosis
Cancer	Hives or Eczema	Venereal Disease

List Any Other Diseases: _____

Do you take an antibiotic before you go to the dentist?_____
Is your tetanus shot up to date? _____

Previous Surgeries	**Year**	**Hospital/City/State**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (please include dosages):_____

_____

Allergies: (please circle)
Penicillin Sulfa Codeine Demerol Morphine Iodine Aspirin Motrin Latex Nickel
LIST ALL OTHER DRUG ALLERGIES: _____
Reactions that occurred: _____
_____

Height: _____ Weight: _____

Patient Social History

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Previously	Currently		
Use of Recreational Drugs:	Never	Type/frequency:_____			

Family Medical History:

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

Review of Systems: (Please indicate personal history below by circling)

CONSTITUTIONAL SYMPTOMS

Good general health lately
Recent Weight Change
Fever
Fatigue

EYES

Eye disease or injury
Wear glasses/contact lenses
Blurred or double vision

CARDIOVASCULAR

Chest pain
Palpitations
Swelling of feet, ankles or hands

RESPIRATORY

Chronic or frequent coughs
Spitting up blood
Shortness of breath
Wheezing

{FEMALES ONLY:}
Are you Pregnant: Yes or No
Are you currently breast feeding:
Yes or No

GASTROINTESTINAL

Loss of appetite
Nausea or vomiting
Frequent diarrhea

GENITOURINARY

Kidney disease
Dialysis
Kidney stones

MUSCULOSKELETAL

Joint pain
Joint stiffness or swelling
Weakness in muscles or joints
Muscle pain or cramps
Back pain
Cold extremities
Difficulty in walking
Neuromuscular disease

INTEGUMENTARY (skin)

Rash or itching
Change in skin color
Change in hair or nails
Varicose Veins

NEUROLOGICAL

Frequent or recurring headaches
Light headed or dizzy
Convulsions or seizures
Numbness or tingling sensations
Tremors
Paralysis
Head injury
Stroke

PSYCHIATRIC

Memory loss or confusion
Depression
Insomnia

ENDOCRINE

Diabetes
Glandular or hormone problem
Excessive thirst or urination
Heat or cold intolerance

HEMATOLOGIC/LYMPHATIC

Bleeding or bruising tendency
Anemia
Phlebitis

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need. I understand that I may be asked to update this form every 6 months for continued medical care.

X_____ _____
Signature of patient (or parent if minor) Date

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