



Welcome to Northwest Foot & Ankle

** The information on this form is necessary for our office to obtain prior to your initial office visit. If this form is not completed in its entirety, you will be delayed in seeing the doctor until the form is complete. Please write on the back if more room is needed. Thank you for your cooperation.

PATIENT INFORMATION: Please complete ALL of the following entries!

Today's Date: _____ Patient Name: _____

Date of Birth: _____ Age: _____ Social Security #: _____ Sex: M F

Home Phone: _____ Cell/Mobile Phone: _____

Address: _____ City, State, Zip: _____

Parent: _____ Parent's Occupation: _____

Parent's Work Phone: _____ Email Address: _____

Nearest relative not living with you: _____ Phone: _____

Nearest relative address: _____

Emergency Contact: _____

Relationship: _____ Emergency Contact Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____ Date last seen by PCP: _____

Pharmacy: _____ Pharmacy Phone: _____

How did you find out about us/Who may we thank for referring you to our office? _____

May we contact you via email for feedback, updates and newsletters? Yes No

PATIENT COMPLAINTS: Check ALL that apply

If this is a **work-related injury**, please notify the receptionist now!

- Headaches Right foot Left foot Corns Flat feet Calluses Pain in heels
- Soft corns Back aches Thick nails Warts Knee pain Ankle sprains Bunions
- Ingrown toe nail Leg cramping Feet cramping Other _____

Please explain your current foot or ankle problem: _____

When did the problem start? _____

What has been done to treat the problem? _____

Are you currently off work due to your pain/injury? Yes No

Have you notified your personnel department? Yes No

If this is a work-related injury, have you started a worker's comp. (L & I) claim? Yes No

If yes, claim #: _____ Name of Employer: _____

Address: _____ City, State, Zip: _____ Phone #: _____

PATIENT HEALTH INFORMATION:

Weight: _____ Height: _____

Shoe Size: _____ Width: _____

How is your general health? Good Fair Poor

Yes No

Do you have a history of low back pain?

Are you regularly tired and exhausted?

At work, do you spend more than 30% of your time on your feet?

Did anyone in your family (mother, father, Grandparents) have similar foot problems?

Have you been treated by a doctor in the past 2 years?

Are you subject to prolonged bleeding?

Is there a family history of diabetes?

Do you smoke cigarettes?

If yes, how many per day? _____

Have you ever fainted in a doctor's or dentist's office?

Have you had previous care by a podiatrist?

Date last seen: _____

Dr's Name: _____

Is your current pain/injury keeping you from regular activities?

SERIOUS ILLNESSES:

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

SURGERIES and HOSPITALIZATIONS:

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

MEDICATIONS/Vitamins, Supplements, and over-the-counter products such as Advil, Tylenol, etc. (include dosage of each): This section is important...Please do not skip!! *If a list is available, please give to the receptionist in order for us to make a copy for your records.

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

Have you ever been treated for any of the following?

- Epilepsy/Seizures Gout Heart Disease
- Stomach ulcer Stroke or Heart Attack
- Phlebitis Diabetes Anemia
- Kidney Bladder Difficulty in healing
- Liver Disease Rheumatic fever
- Thyroid Disease Tuberculosis
- Shortness of breath High/low blood pressure
- Depression or Anxiety Accident/Injury
- Vascular/Circulatory Disease Cancer
- Immune Disease (HIV, AIDS, Hepatitis A, B, C)

Have you experienced any ill effects from any of the following?

- Penicillin Aspirin Cortisone
- Sulfa Drugs Novacain Tape
- Codeine Any antibiotics
- Latex Peanuts

Others, please list: _____

Are you **allergic** to any medications?

If yes, please list ALL: _____

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