Suppan Foot & Ankle Clinic

PATIENT MEDICAL HISTORY

Name: _____ Today's Date: _____

Birthdate: _____

Have you ever had any of the following?

Check all that apply

___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Cancer
___ Blood Clot in Calf of leg
___ Depression
___ Diabetes
___ Epilepsy
___ Excessive bleeding
___ Gout
___ Heart Disease
___ History of stroke in the past year
___ HIV
___ High blood pressure
___ High cholesterol
___ Joint replacement
___ Kidney disease
___ Liver disease
___ Mental disorder
___ Mitral valve prolapse
___ Osteoporosis
___ Pacemaker
___ Paralysis
___ Spine disorder
___ Stroke
___ Thyroid disease
___ **Other disease(s)**
_____
_____

Has a member of your *immediate family*
(mother, father, sister, brother, son, daughter)
had any of the following?

Who?

___ Anesthesia Reaction_____
___ Arthritis _____
___ Blood Disorder_____
___ Cancer _____
Type: _____
___ Diabetes _____
___ Excessive Bleeding_____
___ Heart Disease _____

Drug Allergies: _____

Food/Environmental Allergies: _____

Medications *(please complete **all** sections)* :

Medication Name	***Strength (mg, mcg, etc.)***	***How Many***	***How Often: (Times/Day, etc.)***	***Form (tablet, capsule, etc.)***	***Route (Oral, skin, etc.***

Social History:

Tobacco Current: Y N Former: Y N Cigarettes: Packs per day: _____ for _____ years
Cigar: _____ Chewing Tobacco: _____

Alcohol Y N Drinks per week: _____
Caffeine Y N Cups per day: _____ Pharmacy: _____
Illegal Drugs Y N Type: _____

Are you pregnant? _____

Any problems with Anesthesia, Injections, etc.? _____

Height: _____ Weight: _____ Any falls in the last 6 months _____

Previous Surgeries:

Year:	Operation:

SUPPAN FOOT & ANKLE CLINIC

Please Print

Patient No.: _____ Date Completed: _____

Patient Information:

First: _____ MI: _____ Last: _____

Address: _____ City/State: _____ Zip: _____

Employer: _____ City/State: _____

Social Security No.: _____ Age: _____ Date of Birth: _____

Marital Status: (Circle One) Single/Married/Widow/Divorced

Phone: Home ( ) _____ Bus. ( ) _____ Cell ( ) _____

E-mail address: _____

How do you prefer we contact you? ☐ home ☐ cell ☐ business ☐ e-mail ☐ U.S. mail

EMERGENCY CONTACT: Name: _____ Phone No.: _____

Relationship: _____

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Federal guidelines are requiring us to obtain the following information:

Preferred Language: _____

Do you consider yourself Hispanic/Latino?

- ☐ Yes
- ☐ No
- ☐ Decline to Specify

Gender: ☐ Male ☐ Female

Which category best describes your race?

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Decline to specify

****

Spouse:

First: _____ MI: _____ Last: _____

Address: _____ City/State: _____ Zip: _____

Employer: _____ City/State: _____

Social Security No.: _____ Date of Birth: _____

Parent Information: (mother or father if child)

First: _____ MI: _____ Last: _____

Address: _____ City/State: _____ Zip: _____

Employer: _____ City/State: _____

Phone -- Home: ( ) _____ Business : ( ) _____

Social Security No.: _____ Date of Birth: _____

POA Information:

First: _____ MI: _____ Last: _____

Address: _____ City/State: _____ Zip: _____

Employer: _____ City/State: _____

Social Security No.: _____ Date of Birth: _____

Parent/Guardian: (mother or father if child)

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Were you referred to us? No/Yes If yes, by whom? _____

Family Doctor: _____ City/State: _____

Specialist: _____ City/State: _____