

AFFILIATED FOOT & ANKLE SPECIALISTS OF CLIFTON

Clifton Office:

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Patient Information Form (Please Print)

* Board Certified in Foot & Ankle Surgery

Date: ___/___/___

Patient Name: _____

Date of Birth: ___/___/___ Age: ___ Sex: M F

Home Address: _____

City/State: _____ Zip: _____

Home Phone #: (____) _____ - _____

Cell Phone #: (____) _____ - _____

Work Phone #: (____) _____ - _____

E-mail: _____

Please Circle How You Prefer To Be Contacted: Home Phone Work Phone Cell Phone Email

Do You Have A Legal Guardian Or Healthcare Power Of Attorney? Yes No

If Yes, Name: _____ Relationship: _____ Phone #: (____) _____ - _____

Emergency Contact: _____ Relationship: _____ Phone #: (____) _____ - _____

Primary Care Doctor: _____ Location: _____ Date Last Seen: _____

Pharmacy: _____ Location: _____ Phone #: (____) _____ - _____

Is There a Family Member or Other Person You Would Like For Us to Share Your Medical Information With?

_____ Yes Name(s) _____

_____ No

Who Is Responsible For Payment? _____ Relationship to Patient: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (____) _____ - _____

Quality Measures:

Height: _____ Weight: _____ Shoe Size: _____ Primary Language: _____

Race: Not Specified

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or other Pacific Islander

White

Ethnicity: Not Specified

Hispanic or Latino

Not Hispanic or Latino

Patient Name: _____

Date of Birth: ____/____/____

Please List All Medications You Are Currently Taking:

(Include Prescriptions, Over-The-Counter Medications And Herbal Supplements)

Name	Dose	How Often Do You Take?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please List All Prior Surgeries:

Type of Surgery	Date	Type of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please List All Prior Hospitalizations (Other Than For Surgery):

Reason for Hospitalization	Date	Reason for Hospitalization	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social History:

Marital Status: Single Married Partnered Separated Divorced Widowed

Use of Alcohol: Never No Longer Use History of Alcohol Abuse

Current Use: Rare Occasional Moderate Daily

Use of Tobacco: Never Quit- How Long Ago? _____ Type _____

Current Use: Rare Occasional Moderate Daily

Use of Recreational Drugs: Never Quit- How Long Ago? _____ Type _____

Current Use: Rare Occasional Moderate Daily

Employer: _____ Occupation: _____

How Much Are You on Your Feet At Work: 10% 50% 75% 100%

Do Others Depend Upon You For Their Care? Children Ages(s) _____ Pet(s) What Kind? _____

Elderly or disabled family members Other _____

Exercise: Never Rarely Occasional Weekly Several Times a Week Daily

Types of Exercise: _____

Family History:

Do You Have a Family History of: Diabetes Cancer Heart Disease High Blood Pressure

Strokes Coronary Heart Disease Thyroid Disease Rheumatoid Arthritis

Other _____

Patient Name: _____

Please list all physicians you have seen in the last 5 years and their medical specialty. _____

Your Medical History

Allergies: None Known Medications _____

Anesthesia _____ Foods _____

Tape Latex Shellfish Iodine Other _____

Have You Ever Had Any of The Following?

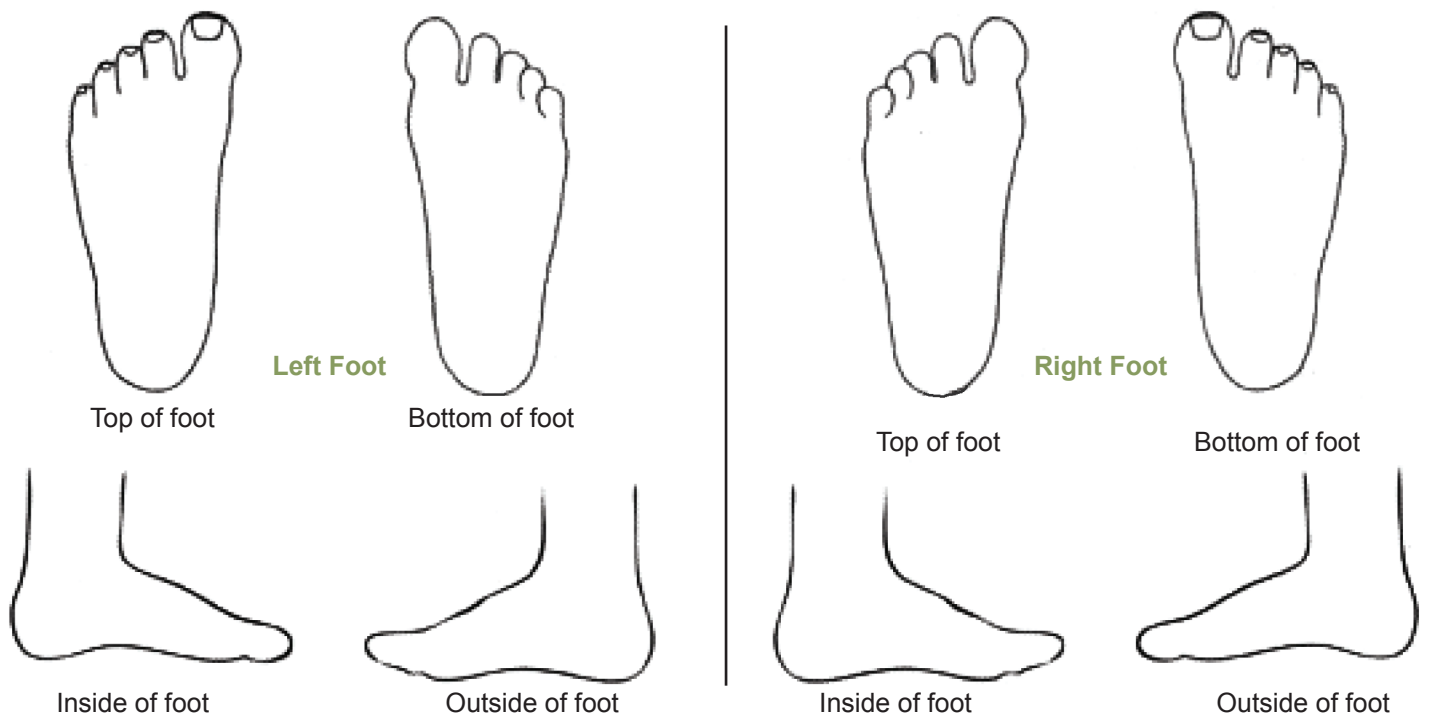
Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

Other Conditions _____

Current Problems

What Specific Problem Brings You to Our Office Today? _____

Where Is The Pain/Problem Located? Please Mark on The Pictures Below.



Patient Name: _____

Date Of Birth: ____/____/____

How Long Ago Did This Problem First Start? _____ Days/ Weeks/ Months/ Years

Did Your Pain Or Problem: Begin All of a Sudden Gradually Develop Over Time

How Would You Describe Your Pain? No Pain Sharp Dull Aching Burning

Radiating Itching Stabbing Other _____

How Would You Rate Your Pain on a Scale From 1 To 10? (Please Circle) 1 2 3 4 5 6 7 8 9 10

Since The Time Your Pain or Problem Began, Has It:

Stayed The Same Become Worse Improved

What Makes Your Pain or Problem Feel Worse? Walking Standing Daily Activities

Resting Dress Shoes High Heels Flat Shoes Any Closed Toe Shoe

Running Other _____

What Makes Your Pain or Problem Feel Better? _____

What Treatments Have You Had For This Problem? _____

How Has This Problem Affected Your Lifestyle And Ability To Work? _____

Was This Problem Caused By An Injury? Yes (Describe) _____ No

If Yes, Was It a Work-Related Injury? Yes No

How Did You Hear About Our Practice? _____

If By Referral, Whom May We Thank For Referring You to Our Office: _____

Search Engine/Website Facebook Advertisement Family or Friend Physician

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Print Name of Patient, Parent or Guardian

Signature of Doctor

If Other Than Patient, Relationship to Patient

Date

Signature

Date