Garden State Foot & Ankle Center, LLC

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MEDICAL HISTORY: Date: _____

Current Foot/Ankle Problem: _____

_____

Describe Your Pain: _____ Duration of Pain? _____

What makes it better? _____ Worse? _____

Weight: _____lbs Height : ____'_____" Last Known Blood Pressure: _____ / _____ Shoe Size: _____

Ever Been to a Foot Doctor Before? _____ Women Only Are You Pregnant/Nursing: _____

For What? _____ What Was Done? _____

Do you have or have you ever been treated for:

- ☐ GERD
- ☐ Stomach Ulcer
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ AIDS/HIV
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Diabetes
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Arrhythmia
- ☐ Valvular Heart Dz
- ☐ Asthma
- ☐ Lung Disease
- ☐ Rheumatoid Athritis
- ☐ Arthritis
- ☐ Osteoprosis
- ☐ Gout
- ☐ Poor Circulation
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Psychiatric Disorder
- ☐ Alzheimers
- ☐ Epilepsy
- ☐ Fibromyalgia/RSD
- ☐ Stroke
- ☐ Hearing/Ear Disorder
- ☐ Glaucoma
- ☐ Nerve Disorder
- ☐ Sciatica
- ☐ Cancer

Past Surgical History: _____

_____

_____

Allergies to Medications: _____

_____

Current Medications: _____

_____

_____

Family History: ☐ Diabetes ☐ Heart Disease ☐ Poor Circulation ☐ Blood Clots ☐ Foot Problems

Social History: Smoking Status: ☐ Former ☐ Current ☐ Never Drink Alcohol Regularly? ☐ Yes ☐ No
Recreational Drug Abuse? ☐ Former ☐ Current ☐ Never

Who Do You Live With? _____Hobbies / Sports? _____

Other: _____

How did you find out about us? _____

SIGNATURE OF PATIENT: _____