ORTHOPAEDIC ASSOCIATES OF SOUTHERN DELAWARE, P.A.
FOOT & ANKLE CENTER
PATIENT HISTORY FORM

PHYSICIAN SIGNATURE_________________________________ DATE: __________

DATE: ____________________

PATIENT NAME: _______________________________________ AGE: ____________________ SHOE SIZE: ___________________________

FAMILY DOCTOR: _______________________________________ WERE YOU REFERRED HERE BY YOUR FAMILY DOCTOR? ☐YES ☐NO

CARDIOLOGIST: _______________________________________ HAVE ANY FAMILY MEMBERS BEEN TREATED BY DRS. ORSINI OR CAPOBIANCO?
☐YES ☐NO IF YES, PLEASE CHECK OFF: ☐MOTHER ☐FATHER ☐SISTER ☐BROTHER ☐CHILD ☐AUNT ☐UNCLE ☐COUSIN

HEIGHT: FT: _____________________ IN: _____________________ WEIGHT: ________________________________ LB

- REASON FOR TODAY'S VISIT: ____

- HOW LONG IN DURATION? ____

- IS YOUR VISIT TODAY DUE TO: ☐AUTO ACCIDENT ☐INJURY AT WORK ☐OTHER: ____

PRESENT AND PAST MEDICAL HISTORY (CHECK YES OR NO):

☐YES	☐NO	PACEMAKER
☐YES	☐NO	HEART ATTACK
☐YES	☐NO	CONGESTIVE HEART FAILURE
☐YES	☐NO	ANGINA
☐YES	☐NO	HIGH BLOOD PRESSURE
☐YES	☐NO	BRONCHITIS
☐YES	☐NO	EMPHYSEMA
☐YES	☐NO	ASTHMA
☐YES	☐NO	TUBERCULOSIS (TB)
☐YES	☐NO	SEIZURES
☐YES	☐NO	STROKES
☐YES	☐NO	LUPUS
☐YES	☐NO	MIGRAINE
☐YES	☐NO	OSTEOPOROSIS
☐YES	☐NO	HIGH CHOLESTEROL
☐YES	☐NO	BLOOD CLOTS
☐YES	☐NO	IMMUNE DISORDER
☐YES	☐NO	DEPRESSION
☐YES	☐NO	ANXIETY
☐YES	☐NO	PSYCHIATRIC DISORDERS
☐YES	☐NO	RHEUMATOID ARTHRITIS
☐YES	☐NO	ARTHRITIS
☐YES	☐NO	KIDNEY STONES
☐YES	☐NO	PSORIASIS
☐YES	☐NO	DIABETES: A1C________________________________
		☐ INSULIN ☐ ORAL MEDICATIONS
☐YES	☐NO	NEUROPATHY
☐YES	☐NO	THYROID DISEASE (☐HYPO ☐ HYPER)
☐YES	☐NO	ARRHYTHMIA (E.G. ATRIAL FIBRILLATION)
☐YES	☐NO	CHRONIC KIDNEY ILLNESS
☐YES	☐NO	FIBROMYALGIA
☐YES	☐NO	HEPATITIS
☐YES	☐NO	GALLSTONES
☐YES	☐NO	LIVER DISEASE
☐YES	☐NO	ULCERS
☐YES	☐NO	GASTROESOPHAGEAL REFLUX
☐YES	☐NO	GLAUCOMA
☐YES	☐NO	GOUT
☐YES	☐NO	CANCER
		*TYPE:
		*DIAGNOSED IN:
		*TREATMENT:
☐YES	☐NO	EXCESSIVE BLEEDING/BLEEDING DISORDERS
☐YES	☐NO	URINARY TRACT INFECTIONS
☐YES	☐NO	LOU GEHRIG'S DISEASE
☐YES	☐NO	MULTIPLE SCLEROSIS
☐YES	☐NO	MYASTHENIA GRAVIS
☐YES	☐NO	HIV
☐YES	☐NO	HISTORY OF MRSA

OTHER: ____

____

(PAGE 2 ON BACK OF THIS FORM)

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PATIENT HISTORY FORM

DO YOU HAVE ANY OF THESE PROBLEMS? (CHECK YES OR NO)

☐YES ☐NO NAUSEA AND VOMITING
☐YES ☐NO FEVER AND C HILLS
☐YES ☐NO NIGHT SWEATS
☐YES ☐NO EASY BLEEDING OR ANEMIA
☐YES ☐NO RASHES OR OTHER SKIN CHANGES
☐YES ☐NO WEIGHT LOSS WITHOUT DIETING
☐YES ☐NO CHEST PAIN

☐YES ☐NO SHORTNESS OF BREATH
☐YES ☐NO WHEEZING
☐YES ☐NO DIZZINESS
☐YES ☐NO UNSTEADY ON YOUR FEET
☐YES ☐NO FAINTING
☐YES ☐NO CHANGES IN SLEEP
☐YES ☐NO BLACK TARRY STOOLS

☐YES ☐NO DECREASE IN ABILITY TO CONCENTRATE
☐YES ☐NO EXCESSIVELY THIRSTY AND UNABLE TO QUENCH THIRST
☐YES ☐NO BOWEL/BLADDER INCONTINENCE

MEDICATIONS: (LIST YOUR MEDICATIONS BELOW) ☐CHECK THIS BOX IF ATTACHING A LIST OF MEDICATIONS

_____________________ _____________________ _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________

- DO YOU HAVE A HISTORY OF DVT OR PULMONARY EMBOLISM (BLOOD CLOTS IN THE LEGS OR LUNGS? ☐YES ☐NO
- DO YOU CURRENTLY TAKE A BLOOD THINNING MEDICATION (E.G. COUMADIN, LOVANOX, WARFARIN, PLAVIX)? ☐YES ☐NO
- DO YOU CURRENTLY TAKE A LOW-DOSE ASPIRIN (325 MG. OR LESS) PER DAY? ☐YES ☐NO

ALLERGIES TO MEDICATIONS: ☐YES ☐NO IF YES, LIST ALLERGIES AND YOUR REACTIONS TO THE MEDICATION: _____________________

____

SOCIAL HISTORY: TOBACCO ☐YES ☐NO ALCOHOL ☐YES ☐NO OTHER: _____________________

SURGERY: (LIST TYPE OF SURGERY AND DATE IT WAS DONE) ☐CHECK THIS BOX IF ATTACHING A LIST OF SURGERIES

_____________________ _____________________ _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________

FAMILY HISTORY: (CHECK ALL THAT APPLY)

☐YES ☐NO RHEUMATOID ARTHRITIS
☐YES ☐NO CANCER
☐YES ☐NO BLEEDING DISORDER
☐YES ☐NO NEUROLOGIC DISEASE
☐YES ☐NO HEART DISEASE
☐YES ☐NO DIABETES

☐OTHER: ____

EMPLOYMENT: ☐ TYPE OF EMPLOYMENT:_____________________ ☐DISABLED ☐RETIRED ☐STUDENT

_____________________________________ _____________________

PATIENT/GUARDIAN SIGNATURE **DATE**

REVISED 4/14/2011 – WORD 2007