ADVANCED ANKLE AND FOOT CENTERS OF FLORIDA
David B. Raynor, DPM

Patient Information:
Full name: _____
Last First Middle
Date of Birth: _____ Age: ____ Social Security Number: _____
Marital Status: __Single __Married __Widowed __Other
Sex: __Male __Female
Home phone number**:** _____Cell phone number: _____

Home Address:
Address: _____
City, State, Zip_____

Billing Address: _____

Employer: _____Phone #_____

Emergency Contact: _____Phone #_____
Relationship: _____

Insurance Company: _____/ _____
Primary **Secondary**
Name of insured
(if other than yourself)_____ Birth date of insured: _____
PLEASE PROVIDE INSURANCE CARD(S) SO THAT WE MAY COPY FOR YOUR RECORD

Referral Information: How did you hear about us?
Name of person / physician referring you to our practice. _____

PATIENT'S MEDICAL HISTORY:
Physician information:
Primary care physician's name:_____Date last seen: _____

Please list all **current medications** (or provide a list we can copy):

_____ _____ _____ _____
_____ _____ _____ _____

List any **allergies** to medicines or food, with reaction: _____
_____

Do you have diabetes? **Yes / No** How long have you had diabetes? _____
What physician is currently treating you for diabetes? _____
Date you last saw this physician? _____How is your diabetes controlled?_____

List any prior surgeries and describe any complications (if any):
_____

Family History: List any family history of disease, relationship and whether still living:

_____

Do you have or have you ever had any of the following?

Stroke	YES/NO	Congestive Heart Failure	YES/NO	Pacemaker	YES/NO
Emphysema	YES/NO	High Blood Pressure	YES/NO	Heart Disease	YES/NO
Angina	YES/NO	Heart Attack	YES/NO	Lung Disease	YES/NO
Ulcers	YES/NO	Coronary Artery Disease	YES/NO	Bleeding Tendency	YES/NO
Arthritis	YES/NO	Gout	YES/NO	Neuropathy	YES/NO
Cancer	YES/NO	Kidney Disease	YES/NO	Asthma	YES/NO
Liver Disease	YES/NO	Thyroid Condition / Goiter	YES/NO	Seizures	YES/NO
Excessive Bleeding	YES/NO	Peripheral Artery Disease	YES/NO	Spine/back	YES/NO
Mitral Valve Prolapse	YES/NO	Swelling of Feet/Ankles	YES/NO		

Others, please list:_____

Social History:

Use of alcohol: __Never __ Rarely __ Moderate __ Daily

Use of tobacco: __Never __ Previously, but quit __ Current ___#packs per day

Height:_____ Weight:_____ __Right hand dominant __Left hand dominant

For women only: Are you pregnant? __yes__no. Are you nursing? __yes__no.

HISTORY OF FOOT PROBLEMS

1. **Onset:**
Approximate date of injury / initial onset of symptoms?_____

2. **Nature of pain:**
What kind pain are you having? Circle: burning, stabbing, shooting, aching, throbbing, tingling, electric, dull, radiating, constant, intermittent, or describe: _____

3. **Rate Pain:** 0 = No pain / 10 = Worst pain you ever had. Circle: 0 1 2 3 4 5 6 7 8 9 10

4**. Location:** Where is the pain? eg: right or left foot, toes, top or bottom of foot, arch, heel, ankle, toenails _____

5. **What symptoms do you have**? Circle: swelling, redness, bruising, burning, itching, numbness, discolored nails, skin flaking, bumps, tiredness, cramping, or describe:

_____

6. **Does the pain travel anywhere?** __**Yes** __**No** Please describe _____

7. **What makes it feel better**? _____**What makes it feel worse**? _____

8. **Are your daily activities limited due to this problem**?_____

9. **Past treatment:**
SELF: What have you done for this problem? _____
PROFESSIONAL: Have you seen anyone for this problem? _____
What advice or treatment was given? _____
Any X-rays taken? If so, where/when? _____