

NEW PATIENT/CONSULTATION FORM

Patient Information, Medical History
and Lower Extremity Examination

DATE: ____/____/____

Driver's license # _____

NAME: Last _____ First _____ Initial _____

AGE: _____ SEX: male female Date of Birth: ____/____/____ Social Security # _____

Referred By: Dr. Mr. Ms. _____ Personal Physician: _____

Date of Last Visit: ____/____/____

PAST MEDICAL HISTORY

Current Medications List:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

- Penicillin Sulfa drugs Aspirin Codeine Iodine/Shellfish Tape
- Local anaesthetics General anaesthetics Latex
- Other antibiotics Other pain medications Non-steroidal medications

Medication allergies: _____

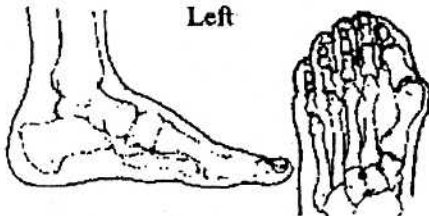
Food allergies: _____

Environmental allergies: _____

Current Problems: (Location, Duration, Onset, Course, Aggravating Factors, Previous Treatments)

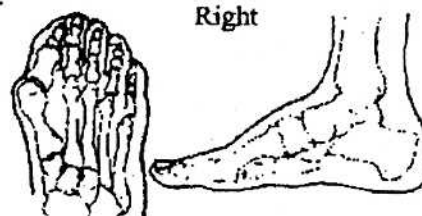
Length of time for current problem:

- days
- weeks
- months
- years



Left

Please use circles and arrows to indicate painful, injured or problem area(s)



Right

ILLNESSES

MAJOR DISEASE:

- Diabetes
- Hypertension
- Angina
- Heart Disease
- Heart Attack
- Arrhythmia
- Murmur
- Mitral Valve Prolapse
- Stroke
- Chest Pain

HEENT:

- Headaches
- Eye Problems
- Hearing Problems

RESPIRATORY:

- Asthma
- Bronchitis
- Frequent Colds
- Lung Disease
- Shortness of Breath
- Tuberculosis
- Emphysema

SOCIAL HISTORY:

Occupation: _____

Athletic Activities: _____

MISCELLANEOUS:

- Epilepsy
- Thyroid Disease
- Muscle Disease
- Kidney Problems
- Bladder Problems
- Prostate Problems
- Venereal Disease
- Skin Conditions
- Cancer History
- Hepatitis

PSYCHOLOGICAL:

- Anxiety
- Depression
- Psychiatric Conditions
- Drug Dependence
- Alcohol Dependence

OTHER ILLNESSES:

ARTHRITIS:

- Osteoarthritis
- Rheumatoid
- Gout
- Sero-negative: Reiter's, PsA, Ankylosing Spondylitis, CCPD, Irritable Bowel

VASCULAR:

- Anemia
- Sickle Cell
- Bleeding Disorders
- Poor Circulation
- Night Cramps
- Leg Pain When Walking
- Vein Problems
- Spider Veins
- Varicose Veins
- Swelling Phlebitis
- Leg Ulcerations
- Blood Clots
- Transfusions

GASTROINTESTINAL:

- Ulcers
- Bowel Disorders
- Stomach Problems
- GI or Rectal Bleeding
- Hiatal Hernia
- Acid Reflux (GERD)

Single

Married

Alcohol: _____ oz/day/week

Tobacco: _____ pks/d for _____ yrs

FAMILY HISTORY:

I hereby give my permission to Dr. Cardon or Dr. Johnson to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account.

Signature of Responsible Party _____

Date _____/_____/_____