FACAROS FOOT & ANKLE

Patient Intake Form

Patient's Name:____ **Date of Birth**:___________________
First Name MI Last Name

Primary Care Physician:______________________________________

Height:__________ **Weight:**__________ **FOR OFFICE USE:** BP - T- P - R -

Allergies(to medicine or foods):____

Pharmacy, Address/Phone #:____

Medications (PLEASE PROVIDE LIST IF POSSIBLE):____

____

Past Medical History:____

____

Do you have or ever had (check all that apply below):

__Diabetes
__Hypertension
__Epilepsy or seizure disorder
__Heart disease or symptoms/chest pain
__Irregular heartbeat
__Lung disease or problems
__Difficulty in breathing
__Blood clots
__Liver disease or problems
__Kidney or bladder disease or problems
__Acid reflux or history of stomach ulcer
__History of blood disorder
__Arthritis
__History of lower back pain/surgery
__Do you experience burning/numbness/spasms in legs/feet?
__For Women: Is there a chance you are pregnant? _____Date of last menstrual period:

Past Surgical History:____

____

Family History:____

Smoking Status: ___Curent smoker: ___Every day ___Occasional___Smokeless Tobacco

___Former smoker (quit date)

___Never

What brings you in today?____

____

Patient or Guardian Signature **Date**