Des Moines University Clinic Foot and Ankle Department
Welcome to our practice!

Please fill out the following information

Name ____

Date of Birth ___________________ Age ____________ M__ F__

Occupation ____

Married___ Single___ Divorced___ Widowed___

Do you have an advance directive or a living will? Yes___ No___

Please indicate any religious, cultural, or spiritual values you wish to be considered in your health care treatment decision making: ______________
____

Medications and Allergies

Please list all current medications. Please indicate all prescription and over the counter drugs as well as birth control pills, herbal medications, and vitamins.

Medication	Dosage / How Often
1.___________________________	___________________________
2.___________________________	___________________________
3.___________________________	___________________________
4.___________________________	___________________________
5.___________________________	___________________________
6.___________________________	___________________________
7.___________________________	___________________________
8.___________________________	___________________________
9.___________________________	___________________________
10.__________________________	___________________________

Allergies	Reactions
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________

Immunizations	Date
Flu Vaccine	___________________________
Pneumonia	___________________________
Tetanus / Pertussis	___________________________
Have you had Shingles Yes__ No__	If yes, date ___________________

Primary Care Physician ______________________________________
____

Referring Physician ______________________________________
____

Pharmacy Name Address ______________________________________
____

Social History (circle yes or no)

Habits FA Drug / Alcohol Use		
Do you drink alcohol?	YES	NO
If yes, how much per week? ___________________________		
Do you use illegal drugs?	YES	NO
If yes, what type? ___________________________		
Do you drink caffeine?	YES	NO
If yes, what type and how often ___________________________		
Do you use or have you used tobacco?	YES	NO
If yes, check one: ____ Current user or ____ Former use		
What type of tobacco used? ___________________________		
How often and how much tobacco used? ___________________________		
If you have quit using tobacco, how long did you use tobacco and when did you quit ___________________________		
Do you live alone?	YES	NO
Activities FA		
Do you exercise?	YES	NO
If yes, what activity?		
How many days per week? ___________________________		
Time / Duration (minutes)? ___________________________		
Shoes and Inserts		
What is your shoe size? ___________________________		
What brand of shoes do you wear for exercise? ___________________		
Do you wear inserts or orthotics?	YES	NO
If yes, are they custom-made for your foot?	YES	NO
History of Testing		
Bone Density Scan Date ___________________________		
Results check one ____ Normal or ____ Abnormal		

	Check any disease / condition current or past Medical History
	AIDS / HIV
	Alcoholism
	Allergies Environmental
	Allergies Seasonal
	Alzheimer's
	Anemia
	Anesthesia Complications
	Anxiety
	Arthritis
	Asthma
	Back Pain
	Blood Disorder
	Blood Clots
	Blood Transfusions
	Cancer / what type
	Dementia
	Depression
	Diabetes
	Emphysema / Lung
	Eye Disease
	Foot / Leg Ulcer
	Glaucoma
	Heart Disease
	High Blood Pressure
	High Cholesterol
	Joint Pain
	Kidney Disease
	Kidney Stones
	Liver Disease
	Migraines
	Osteoporosis
	Pneumonia
	Reflux (gastric)
	Seizures
	Sexually Transmitted Disease
	Stroke
	Thyroid Disease
	Other

Comments on Medical History

Hospitalizations within the last 18 months	
Reason	Date Mo / Year

	Surgery – describe type	Date Year
	Back Surgery	
	Eyes	
	Heart Surgery	
	Kidney / Organ Transplant	
	Lower Extremity Bypass	
	Joint / Bone	
	Hip – Fracture / Replacement	
	Knee – Arthroscopic / Replacement	
	Other	
	Foot, Ankle Surgery or Foot Trauma	
	Type	

Family History Use the key to indicate if any of your family members currently have or have had any of the conditions / diseases listed.

M=Mother F=Father Sister B= Brother C=Children

Disease / Condition	M	F	S	B	C
AIDS/ HIV					
Alcoholism					
Alzheimer's / Dementia					
Anemia					
Anesthesia Problems					
Anxiety					
Arthritis					
Asthma					
Bleeding Disorders					
Blood Clots					
Cancer / type					
Depression					
Diabetes					
Emphysema					
Glaucoma					
Heart Disease					
High Cholesterol					
High Blood Pressure					
Kidney Disease					
Migraines					
Osteoporosis					
Seizures					
Stroke					
Thyroid Disease					
Tuberculosis (TB)					

Review of Systems: Please check the symptoms you are having now

	Fever		Urinary incontinence
	Weight gain / loss		Difficulty urinating
	Sweats		Frequent urination
	Chills		
			Itching
	Chest pain / discomfort		Rash
	Palpitations		
	Short of breath w/ walking		Fainting
	Short of breath lying down		Numbness
			Tingling
	Cough		Dizziness
	Coughing up blood		Headaches
	Shortness of breath		
	Sleep apnea		Anxiety
			Depression
	Vomiting		Feeling unsafe in relationship
	Nausea		
	Diarrhea		Fatigue / tired
	Constipation		Excessive thirst
	Heartburn		
			Easy bruising
	Muscle aches		Excessive bleeding
	Joint pain		
	Swelling of feet / legs		
	Leg cramping		

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PATIENT SIGNATURE AND DATE