Bakersfield Foot and Ankle Surgeons

MEDICAL FORM

Patient____ Date_____/_____/_____

Social Security #: _________________________________ Date of Birth_____/_____/_____ Age________

Sex: Male ____ Female ____ Occupation ______________________________

Ethnicity:____________________________

Current primary care physician ____MD/DO

Previously seen podiatrists or orthopedists ____

CURRENT FOOT/ANKLE PROBLEM

In your own words, what foot/ankle brought you to our office today?

____

____

How long has this problem been present? ____________________

Can you think of any incident which could have triggered the problem? (explain)

____

____

What have you done to relieve the foot/ankle problem? __________________________________

____

What foot/ankle problems are you currently having or have had?

Problem	Currently Have	Previously Had	Right	Left
Ankle pain	☐	☐	☐	☐
Arch pain	☐	☐	☐	☐
Athlete's foot	☐	☐	☐	☐
Bunion	☐	☐	☐	☐
Corn	☐	☐	☐	☐
Callus	☐	☐	☐	☐
Cramps, foot	☐	☐	☐	☐
Cramps, leg	☐	☐	☐	☐
Flatfoot	☐	☐	☐	☐
Foot pain	☐	☐	☐	☐
Fungus nails	☐	☐	☐	☐
Heel pain	☐	☐	☐	☐
Infection, foot/ankle	☐	☐	☐	☐
Ingrown toenail	☐	☐	☐	☐
Intoeing	☐	☐	☐	☐
Numbness, foot	☐	☐	☐	☐
Sweating, Excessive	☐	☐	☐	☐
Swelling, ankle/foot	☐	☐	☐	☐
Toe pain	☐	☐	☐	☐
Wart	☐	☐	☐	☐

Is your foot problem the result of an injury? Yes ___ No ___

If yes, what is the date of injury? _____/_____/_____

Where did the injury occur? ____

____

If the injury occurred at work, has your employer been notified? ____________________

Employer____________________________________ Occupation__________________

Address____

City_____________________________________ State__________ Zip ___________

Employer Phone # (______)____________________ Contact Person_______________

GENERAL MEDICAL HISTORY

Please indicate whether you have a personal or family medical history of any of the following:

Problem	Yes, Personal History	Yes, Family History
Arthritis, osteoarthritis	☐	☐
Arthritis, rheumatoid	☐	☐
Artificial heart valve	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chest pain	☐	☐
Circulation problems	☐	☐
Diabetes	☐	☐
Fainting	☐	☐
Foot cramps	☐	☐
Gout	☐	☐
Headaches, chronic	☐	☐
Heart disease	☐	☐
High blood pressure	☐	☐
Kidney problems	☐	☐
Leg cramps	☐	☐
Liver disease	☐	☐
Low blood pressure	☐	☐
Respiratory disease	☐	☐
Shortness of breath	☐	☐
Stroke	☐	☐
Swelling, ankle(s), chronic	☐	☐
Swelling, foot, chronic	☐	☐
Swelling, leg(s), chronic	☐	☐
TB	☐	☐
Ulcers, skin	☐	☐
Ulcers, stomach	☐	☐
Varicose veins	☐	☐
Other: __________________________	☐	☐
Other: __________________________	☐	☐

List the surgeries you have had (both minor and major): _________________________________

____

____

List any hospitalizations (other than for the surgeries above) you have had: _________________

____

____

Are you now, or have you been, under any other doctor's care for any reason over the past two years?
Yes ___ No ___

If yes, please list the names of your doctors (including your primary care physician – PCP):

PCP: ____ City ____________________________

Other Physicians: ____

____

CONSENT

I certify that the above information is true and correct to the best of my knowledge.

I give my permission for Bakersfield Foot and Ankle Surgeons to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

____ ___________________

Patient or Guardian's Signature Date