WASHINGTON HEALTH SYSTEM
Foot and Ankle Specialists

208 WELLNESS WAY
BUILDING # 1
WASHINGTON, PA 15301
PHONE 724-222-5635

PATIENT INFORMATION

Last Name_____ First Name _____MI_____

Greeting (Other name you wish you be called) _____ PCP _____

How did you hear about us? _____

Address_____City_____State_____Zip Code_____

Home Phone _____Work Phone _____Cell Phone _____Date of Birth_____

Sex: Male/Female Marital Status: M D W S Other Social Security #:_____

RACE INFORMATION ☐ White, ☐ Black or African American, ☐ Asian,☐ Alaskan Native or American Indian, ☐ Hispanic or Latino, ☐ Non- Hispanic or Latino, ☐ other_____, ☐ I prefer not to Disclose

PREFERRED LANGUAGE ☐ English, ☐ Spanish, ☐ German, ☐ Sign Language, ☐ Other, ☐ I prefer not to disclose

Patient's Employment_____Address_____Phone#_____

Emergency Contact_____ Phone#_____ Relation to Patient_____

Type of Payment: Insurance/Self Pay

IF PATIENT IS A MINOR: Mother's Full Name_____ Father's Full Name_____

Legal Guardian's Full Name_____

Do you have a living will? Yes No Do you have an advanced directive? Yes No

ALLERGIES: Please include all medications, foods, and environmental allergies.

☐ None ☐ Anesthesia ☐ Latex ☐ Iodine ☐ Shellfish ☐ Tape

_____ _____

_____ _____

MEDICATIONS (List any/all of your current prescriptions including over the counter medications and vitamins/herbs

_____ _____

_____ _____

_____ _____

_____ _____

PREGNANCY Are you pregnant or planning to be pregnant? ☐ **Yes** ☐ **No**

WASHINGTON HEALTH SYSTEM
Foot and Ankle Specialists

208 WELLNESS WAY
BUILDING # 1
WASHINGTON, PA 15301
PHONE 724-222-5635

PAST MEDICAL HISTORY **(PLEASE CIRCLE ALL THAT APPLY)**

Aids/HIV+

Alcohol Abuse

Anemia

Anesthesia Problems

Angina

Anxiety

Arthritis

Asthma

Atrial Fibrillation

Back Pain, Chronic

Balance/Fall Disorder

Bleeding/Bruising Tendency

BPH (Enlarged Prostate)

Breast CA

Bronchitis, Chronic

Cardiomyopathy

Cerebral Palsy

Charcot Foot

Charcot Marie Tooth Disease

CHF

Colon CA

COPD

Coronary Artery Disease

Chronic Renal Disease

Chronic Renal Insufficiency

CVA (Stroke)

Dementia

Depression

Dermatitis

Diabetes Type 1 Controlled

Diabetes Type 1 Uncontrolled

Diabetes Type 2 Controlled

Diabetes Type 2 Uncontrolled

Dizziness (Vertigo)

DJD

Drug Abuse

Eczema

Emphysema

Epilepsy

Fibromyalgia

GERD (Heartburn)

Glaucoma

Gout

Headaches

Headaches (Migraine)

Heart Attack (MI)

Heart Murmur

Hepatitis

Hyperlipidemia

Hypertension

Hyperthyroidism

Hypothyroidism

Irregular Heart Beat

Irritable Bowel

Kidney Disease

Kidney Stones

Lumbar Stenosis

Lupus

Lymphedema

Menopausal Symptoms

Mental Illness

Muscular Dystrophy

Obesity

Osteoarthritis

Osteomyelitis

Osteopenia

Osteoporosis

Palpitations

Parkinson's Disease

Peptic Ulcer Disease

Peripheral Neuropathy

Peripheral Vascular Disease

Phlebitis

Polio

Prostate CA

Psoriasis

Pulmonary Embolism (Blood Clot in Leg)

Rheumatoid Arthritis

Rheumatic Fever

Restless Legs Syndrome

Scleroderma

Sciatica

Scoliosis

Sexually Transmitted Disease

Sickle Cell

Sleep Apnea

SOB (Shortness of Breath)

Tobacco Use Disorder

Tuberculosis

Tumor/Cysts Bone/Skin

Ulcers

Varicose/Spider Veins

Warts

Weight Gain

Weight Loss

Wounds

WASHINGTON HEALTH SYSTEM
Foot and Ankle Specialists

208 WELLNESS WAY
BUILDING # 1
WASHINGTON, PA 15301
PHONE 724-222-5635

HOSPITALIZATIONS (Reason) **DATE**

_____ _____

_____ _____

SURGERIES **DATE** **Date**

Amputation _____ Hyperbaric Oxygen Therapy _____

Back/Neck _____ Knee Replacement _____

Blood Transfusions _____ Pacemaker _____

Bypass in leg _____ Cardiac Cath _____

Chemotherapy/Radiation _____ Fractures _____

Foot/Ankle Surgeries _____ Gastric Bypass Surgery _____

Hip Replacement _____ Other _____

_____

List any diagnostic studies (MRI, CT, bone scan, Vascular Studies, EMG/ NCV, Blood work, Cultures) you have had for this condition along with a date of when and where the study was performed.

FAMILY HISTORY (Please circle illness and state family member/relative.

Illness/Type	Family Member	Illness/Type	Family Member
Breast Cancer	_____	Amputations	_____
Ovarian Cancer	_____	Anesthesia Problems	_____
Colorectal Cancer	_____	Rheumatoid Arthritis	_____
Prostate Cancer	_____	Osteoarthritis	_____
High Blood Pressure	_____	Psoriatic	_____
Heart Disease	_____	Scleroderma	_____
Diabetes	_____	Lupus	_____
Stroke	_____	PVD	_____
Depression	_____	Gangrene	_____
Anxiety	_____	Raynauds	_____
Glaucoma	_____	Other	_____
Alcohol/Drug Abuse	_____	Other	_____
Foot/Ankle problems/ surgeries	_____	Other	_____

WASHINGTON HEALTH SYSTEM
Foot and Ankle Specialists

208 WELLNESS WAY
BUILDING # 1
WASHINGTON, PA 15301
PHONE 724-222-5635

SOCIAL HISTORY

Smokes Yes No If Yes, Packs per day_____ For how many yrs._____

Exercise Yes No If Yes, Mild intensity _____ Moderate intensity_____

Nutrition Yes No Type of Diet_____

Alcohol Use Yes No Daily_____ Weekly_____ Monthly_____ Yearly_____ What type_____

Drug Use Yes No Marijuana_____ Street Drugs_____ IV Drugs_____

PREVENTION

Eye Exam (Diabetic) Yes Date_____ Nutritional Counseling Yes Date_____

Dexa Bone Density Yes Date_____ EKG Yes Date_____

Foot Exam Yes Date_____ Smoking Cessation Yes Date_____

Patient Name: _____ **Date:** _____

WASHINGTON HEALTH SYSTEM
Foot and Ankle Specialists

208 WELLNESS WAY
BUILDING # 1
WASHINGTON, PA 15301
PHONE 724-222-5635

Please complete and answer all questions. Thank you.

HISTORY OF PRESENT ILLNESS:

1. What specific problem brings you to our office today? _____
2. Where is the pain/condition located? ☒ left foot/ankle ☒ Right foot/ankle ☒ Both
3. What part of the foot/ ankle is the pain/condition located?
   ☒ toe ☒ forefoot ☒ mid-foot ☒ heel ☒ ankle ☒ leg
4. How would you describe the nature of pain/condition? ☒ sharp ☒ dull ☒ aching ☒ burning
   ☒ radiating ☒ shooting ☒ itching ☒ stabbing ☒ throbbing ☒ numbness ☒ tingling
   ☒ other: _____
5. How would you rate your pain on a scale from 0 to 10?
   (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) ☒ pain varies
6. Your pain/condition occurs for: ☒ minutes ☒ hours ☒ continual ☒ when weight bearing
   ☒ when non-weight bearing
7. Your pain/condition started ☒ sudden ☒ gradual ☒ several days ago ☒ weeks ago ☒ months ago ☒ years ago, ☒ unknown ☒ other_____
8. Your pain/condition occurs: ☒ just out of bed ☒ as the day progresses ☒ at the end of day ☒ just at night ☒ improves over time ☒ as an injury ☒ other ____
9. Your pain/condition feel s ☒ worse or ☒ improves when going/wearing:
   ☒ walking ☒ standing ☒ resting ☒ barefooted ☒ slippers ☒ tennis shoes ☒ dress shoes ☒ high heels ☒ flat shoes ☒ any closed-in shoe ☒ sandals/ flip-flops ☒ other _____
10. Your pain/condition affects your: ☒ ability to perform daily activities ☒ ability to work ☒ school activities ☒ ability to exercise ☒ lower back ☒other: _____

PLEASE EVALUATE YOUR FOOT/ANKLE PROBLEM AS:

☒ New
☒ Recurring
☒ is/has improving/improved
☒ is/has resolving/resolved
☒ is/has worsening/worsened
☒ is the same

IF YOU ARE DIABETIC: ☒ Insulin Dependent ☒ Oral Mediation ☒ Diet & Exercise Managed

Your last Fasting Blood Sugar (FBS) reading_____ Your last A1C reading_____

Have you noticed any changes in your feet since last foot exam? (Please explain)_____
_____
Have you noticed any changes in your shoe gear since the last exam? (Please explain) _____
_____

FOR ALL PATIENTS WHO MAY NEED A PRESCRIPTION AS PART OF TODAYS TREATMENT:

Your preferred pharmacy is: _____

Phone #: _____

WASHINGTON HEALTH SYSTEM
Foot and Ankle Specialists

208 WELLNESS WAY
BUILDING # 1
WASHINGTON, PA 15301
PHONE 724-222-5635

REVIEW OF SYSTEMS

Below is a list of symptoms that seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

***** **Please only mark if you have had these symptoms within the last 3 weeks.**

Constitutional: ☒ **I DENY having or have had any of the symptoms or problems listed below.**
☒ chills ☒ fatigue ☒ night sweats ☒ dizziness ☒ insomnia ☒ fever ☒ weight gain ☒ weight loss

Eyes/Vision: ☒ **I DENY having any of the symptoms or problems listed below**
☒ change in vision ☒ blurred vision ☒ double vision ☒ tearing ☒ eye pain ☒ itching ☒ dry eyes

Ears, Nose, and Throat: ☒ **I DENY having any of the symptoms or problems listed below**
☒ ear drainage ☒ hearing loss ☒ nosebleeds ☒ sore throat ☒ difficulty swallowing ☒ ear pain
☒ hoarseness ☒ ringing in ears ☒ discharge ☒ loss of smell ☒ sinus problem ☒ dizziness ☒ headaches
☒ nasal congestion ☒ lost of taste

Cardiovascular: ☒ **I DENY having any of the symptoms or problems listed below**
☒ chest pain ☒ high/low blood pressure ☒ swelling of legs/feet ☒ calf pain ☒ heart problems
☒ palpitations ☒ rapid heart rate ☒ varicose veins

Respiratory: ☒ **I DENY having any of the symptoms or problems listed below**
☒ asthma ☒ coughing up blood ☒ wheezing ☒ excess mucus ☒ shortness of breath ☒ cough ☒ shortness of breath
☒ chest pain with breathing

Gastrointestinal: ☒ **I DENY having any of the symptoms or problems listed below**
☒ abdominal pain ☒ diarrhea ☒ nausea ☒ vomiting ☒ belching ☒ excess gas ☒ rectal bleeding ☒ vomiting blood
☒ black-tarry stools ☒ heartburn ☒ constipation ☒ indigestion

Female: ☒ **I DENY having any of the symptoms or problems listed below**
☒ breast pain ☒ cramps ☒ irregular menstruation ☒ vaginal bleeding ☒ burning urination ☒ frequent urination
☒ bloated ☒ vaginal discharge ☒ fluid retention

Male: ☒ **I DENY having any of the symptoms or problems listed below**
☒ burning urination ☒ erectile dysfunction ☒ urine retention ☒ frequent urination ☒ prostrate problems

Endocrine: ☒ **I DENY having any of the symptoms or problems listed below**
☒ cold intolerance ☒ excessive thirst ☒ heat intolerance/hot flashes ☒ excessive appetite ☒ thyroid problems
☒ unusual hair growth ☒ excessive hunger ☒ hair loss ☒ voice changes

Skin: ☒ **I DENY having any of the symptoms or problems listed below**
☒ changes in toenails ☒ hives ☒ skin lesions ☒ excessive dryness ☒ changes in skin color ☒ itching ☒ ulcers
☒ fungus toenails ☒ hair growth ☒ rash ☒ sweatiness ☒ corns/calluses ☒ drainage ☒ odor

Musculoskeletal : ☒ **I DENY having any of the symptoms or problems listed below**
☒ Joint pain ☒ muscle weakness ☒ restless legs ☒ joint stiffness ☒ joint swelling ☒ leg/foot pain when walking
☒ back pain ☒ loss of motion ☒ difficulty with walking ☒ instability ☒ mass/lump

Nervous System: ☒ **I DENY having any of the symptoms or problems listed below**
☒ dizziness ☒ loss of consciousness ☒ seizures ☒ spasms ☒ limb weakness ☒ numbness/ tingling ☒ sleep disturbance ☒ loss of balance ☒ headaches ☒ loss of memory ☒ burning ☒ fear of falling

Psychological: ☒ **I DENY having any of the symptoms or problems listed below**
☒ behavioral change ☒ anxiety ☒ depression ☒ mood change ☒ loss or change in appetite ☒ claustrophobia
☒ confusion ☒ sleeping disturbance

Allergy: ☒ **I DENY having any of the symptoms or problems listed below**
☒ anaphylaxis ☒ itching ☒ sneezing ☒ hives ☒ food intolerance ☒ rash ☒ nasal congestion

Hematological/Lymphatic : ☒ **I DENY having any of the symptoms or problems listed below**
☒ anemia ☒ blood clotting ☒ fatigue ☒ bleeding ☒ bruising easily ☒ lymph node swelling