Affiliated Foot & Ankle Center

Dr. Scott H. Andrew

MEDICAL HISTORY

Patient Name: _____ Date:_____

Male:_____Female:_____Transgender:_____

How does your insurance company have you listed? Male_____Female_____Transgender_____

Date of Birth**:** _____
How did you find out about Dr. Andrew:_____

WHY ARE YOU HERE TODAY? WHAT IS YOUR FOOT COMPLAINT:

Is this a Worker's Compensation related injury? ( ) Yes ( ) No

Emergency Contact:_____Phone #:_____

Who is responsible for payment? Name:_____ Date of birth?_____

I have been given a copy of the HIPAA privacy law: ( ) Yes

Mark any conditions that you have been diagnosed with:

( ) Anemia
( ) Arthritis
Type:
( ) Asthma
( ) Autoimmune Disease
Type:
( ) Blood Clots
( ) Cancer
Type:
( ) Congestive Heart Failure
( ) COPD
( ) Depression
( ) Diabetes
( ) Emphysema
( ) Eye Problems
( ) Fibromyalgia
( ) GERD
( ) Gout
( ) Heart Disease
( ) Hepatitis
Type:
( ) Heart Attack
( ) High Blood Pressure
( ) High Cholesterol
( ) HIV
( ) Implants
Where:
( ) Infectious Disease
Type:
( ) Irregular Heart Beat
( ) Kidney Disease
( ) Liver Disease
( ) Lung Disease
( ) Lupus
( ) Muscular Disorder
( ) Neurological Disorder
( ) Osteoporosis
( ) Pacemaker
( ) Parkinson's
( ) Scleroderma
( ) Stoke
( ) Thyroid Condition

Are you pregnant? ( ) yes ( ) no

List any other health conditions not listed on this form:

_____

Check boxes describing symptoms you currently have recently had or have on a regular basis:

( ) Acid Reflux
( ) Anxiety
( ) Cough
( ) Confusion
( ) Decreased Hearing
( ) Decreased Vision
( ) Difficulty Breathing
( ) Dizziness
( ) Fainting
( ) Forget fullness
( ) Muscle Cramps
( ) Muscle Weakness
( ) Nausea
( ) Nerve Pain
( ) Burning
( ) Pins & Needles
( ) Shooting pains
( ) persistent Infections
( ) Rash
( ) Shortness of Breath
( ) Tiredness

Health symptoms not listed above:

List any MEDICATION & FOOD allergies you have as well as ADVERSE REACTION YOU HAVE:
Patient Name:_____Today'sDate:_____
Allergic to: **Adverse Reaction you have when exposed to allergen:**
I have no allergies ( )
1._____ 3._____
2._____ 4._____

MEDICATIONS TAKING, DOSE, FREQUENCY:
I take no medications ( )

Drug	**Dose**	**Times Taken Per Day**	**Drug**	**Dose**	**Times Taken Per Day**
1._____	_____	_____	4._____	_____	_____
2._____	_____	_____	5._____	_____	_____
3._____	_____	_____	6._____	_____	_____

I HAVE HAD NO SURGERIES ( )
List all **surgeries** you have had:
1._____
2._____
3._____
4._____
5._____

SOCIAL
Tobacco use: Do you use any tobacco? ( ) yes ( ) no Type of tobacco:
( ) Current user/smoker ( ) Former user/smoker Duration of use:_____ Daily use:____

Alcohol use: Drinks per ( )day ( )month ( )year ____ ( ) beer ( ) wine ( ) liquor
Illicit drugs: Do you use any? ( )yes ( )no Type:_____ How long:_____ How often:_____
Prescription drugs taken for use other than what prescription indicates? ( )yes ( )no
_____

FAMILY HISTORY:

	Family Member		Family member
( ) Arthritis	_____		
		( ) Heart attack	_____
( ) Auto-immune disease	_____	( ) High blood pressure	_____
( ) Cancer	_____	( ) High cholesterol	_____
( ) Diabetes	_____	( ) Malignant Hyperthermia—this an adverse reaction to IV or General sedation	_____
		( ) Stroke	

OTHER:_____

Who is your primary care doctor?_____
Do you consent to X rays taken in my office if deemed necessary by Dr. Andrew? ( ) yes ( ) no

PHARMACY NAME & LOCATION:_____
I attest to the information given on my medical history is correct and factual. By signing this form, I authorize the healthcare staff to perform the necessary services I need.

Print Name:_____DATE_____Signature:_____