Bay Foot & Ankle Center

MEDICAL HISTORY

Patient Name: Date of Birth: / /

Reason for visit:

If any, where is your pain located on your foot/ankle?

How long has it been present? ☐ Days [ ] ☐ Months [ ] ☐ Years [ ]

Previous treatments? ☐ Surgery ☐ Orthotic Devices ☐ Medication ☐ Injections

Shoe Size: Height: Weight:

Primary Care Physician: Phone Number:

PAST MEDICAL HISTORY (Please Check which of the following you have or have had in the past)

☐Arthritis/Rheumatological problems	☐Hep B (serum)
☐Anemia	☐High Blood Pressure
☐Asthma/Apnea	☐HIV positive
☐Bleeding disorder	☐Kidney Disease
☐Blood clot history	☐Motion Sickness
☐Diabetes (Type 1)	☐Neurological Disorder
☐Diabetes (Type 2)	☐Psychiatric Care
☐Fibromyalgia	☐Stomach Ulcers/GERD/Upset
☐Glaucoma	☐Skin disorders
☐Heart Condition (Surgery, Disease)	☐Stroke/TIA
☐Hep A(infectious)	☐Vein/Circulation problems

☐Other (please specify):

Are you pregnant? ☐ No ☐ Yes If yes, how many weeks?

SOCIAL HISTORY

Do you drink? ☐ No ☐ Yes If yes, how many drinks per week?

Do you smoke? ☐ No ☐ Yes If yes, how many pack(s)/day? For how long?

Have you ever smoked? ☐ No ☐ Yes When did you quit?

Hobbies:

I acknowledge the above medical information provided is necessary to provide me with medical care safely. I have answered all the questions to the best of my knowledge.

	x	/ /
Patient or Legal Guardian Name	Signature	Date

PAST SURGERIES AND ALLERGIES

Please list any previous surgeries including foot/ankle and the date on which they were performed:

_____

Please list all known allergies or reactions to drugs/medications:

☐ Penicillin ☐ Local anesthetic ☐ Iodine ☐ Codeine ☐ Tape/Latex ☐ Sulfa
☐ NSAID's ☐ Other (please specify)

MEDICATIONS

Please list all medications you are currently taking including prescription and over the counter:

MEDICATION	**DOSE**	**Frequency**

PHARMACY INFORMATION

Preferred Pharmacy: ☐ Publix ☐ Walmart ☐ Walgreens ☐ CVS ☐ Eglin AFB ☐ None

☐ Other (please specify) _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone:

I authorize Bay Foot and Ankle Center and its providers to obtain and view my external prescription history through Surescripts services.

_____ x_____ ____/___/____

Patient or Legal Guardian Name Signature Date

I acknowledge the above medical information provided is necessary to provide me with medical care safely. I have answered all the questions to the best of my knowledge. I give my permission to further inquire with my respective health care providers and to release my medical record information as needed. I will notify you if any changes occur in my health and/or medication list accordingly. I also authorize Dr. Francia T. Squatrito and her staff to examine and treat the lower extremity of the patient as deemed necessary.

_____ x_____ ____/___/____

Patient or Legal Guardian Name Signature Date