Patient Name ___________________________ Date of Birth __________________ Today's date_______________

PATIENT MEDICAL INFORMATION/HISTORY

*Primary foot /ankle problem*____ date of onset_______________

Previous treatment(s)____

___Right foot/ankle ___Left foot/ankle ___Hallux (big)toe ___2nd toe ___3rd toe ___4th toe ___5th (pinky) toe

*Secondary foot / ankle issue*____ date of onset__________________

___Right foot/ankle ___Left foot/ankle ___Hallux (big)toe ___2nd toe ___3rd toe ___4th toe ___5th (pinky) toe

Previous treatment(s)____

____

Vitals – Height (**in inches**) _______________ Weight (in pounds) ______________ Shoe size _______________________

ALLERGIES (mark if yes) ____Adhesives ____Anesthetics ____Environmental ____Latex

ALLERGIES TO MEDICATIONS____

____

CURRENT MEDICATIONS – *List name of medication, strength, dosage* (use separate sheet of paper if necessary)

Name	Strength	Dosage	Name	Strength	Dosage

____

PAST MEDICAL HISTORY – mark each that apply OR **If none apply *check here*** _____

___Aids/HIV
___Alcoholism
___Anemia
___Anesthesia reaction
___Anxiety
___Arthritis-Osteo
___Arthritis-Rheum.
___Asthma
___Bleeding disorder
___Cancer_________
___Cholesterol-high
___Claudication
___COPD
___Dementia/Alzheimers
___DVT
___Emphysema
___Fibromyalgia
___GI –Celiac/Crohns
___GI – Colitis/IBS
___GI – Gerd/Reflux
___GI- Ulcer
___Gout
___Heart disease
___Heart-Arrhythmia
___Heart –CHF
___Heart-Murmur
___Hepatitis
___Herpes/Shingles
___High blood pressure
___Kidney disease/dialysis
___Liver disease
___Lower extremity ulcer(s)
___Lupus
___Lymphadema/swelling
___Multiple Sclerosis
___Neurological disorder/
___Parkinsons disease
___Osteoporosis
___Phlebitis
___Psoriasis
___Peripheral arterial disease (PAD)
___Psychiatric problems ___________
___Raynaud's disease
___Seizures/Epilepsy
___Sexually transmitted disease
___Stroke
___Syncopy/dizziness/faint
___Thyroid disorder
___Varicose veins
___Vascular disease
___Other – list_____________________
____
____

___Diabetes** **Date of diabetic diagnosis**_____________________________

Doctor treating your diabetes__________________________________ **Date last seen (mo,day,yr)** ______________

Phone #_______________________ **your most recent A1c result and date of test**___________________________

Call your treating physician's office if A1c and dates are not known.

Patient Name ______________________________________Date of Birth_________________ Todays date ____________

PAST SURGICAL HISTORY- List all surgeries & dates (or at least year), note right, left, 1-5 finger/toe etc.
Use separate sheet of paper if necessary.

1.____________________ 2.____________________ 3.____________________ 4.____________________
5.____________________ 6.____________________ 7.____________________ 8.____________________

Previous Foot Surgery – Type of Surgery__________________ Date_____________ Why______________________
Previous Foot Surgery - Type of Surgery__________________ Date_____________ Why______________________

FAMILY HISTORY (check here if unknown_____)

**** ***Please mark***: **M** - maternal side of family **P** - paternal side of family or **S** - sibling

___Allergies
___Alzheimers/Dementia
___Anesthesia
___Arthritis – Osteo
___Arthritis – Rheumatoid
___Bipolar disorder
___Cancer (type)____________
___ G. I. disease
___Depression
___ Diabetes
___Heart disease
___High blood pressure
___High cholesterol
___Migraines
___Stroke
___Vascular disease
___Other (list)______________
____

SOCIAL HISTORY

Alcohol ___ never
___# of drinks per day
___social drinker
___recovering alcoholic

Caffeine # ____ servings per day

Children #_____________

Employment - ___disabled
___ part time ___full time
___ retired ___unemployed

Exercise -___never
___sporadic
___moderately or more

Live with ___ alone
___children
___partner
___spouse
___spouse & kid(s)
___other

Smoking -___never
___less than ½ pack per day
___over ½ pack per day
___former
___Chew Tobacco

___Student – full time
___Student – part time

Other ________________________
____

INFORMATION/COLLECTION AUTHORIZATION AND ASSIGNMENT OF BENEFITS RELEASE

I have fully completed all forms and certify that I am the patient or responsible party for the patient. I understand that even though the patient has some type of insurance coverage, I am responsible for obtaining/maintaining authorization referrals and payment of services. In the event these services go unpaid, collection procedures may occur and I will be responsible for all attorney fees and collection costs. I authorize release of information necessary to file/reconcile a claim with my/patients' insurance company and assign all benefits to be paid directly to the doctor. I authorize Dr. Jeffrie Leibovitz, or whomever he may designate as his assistant, to exam and treat me/or the patient. Examination and treatment may include further lab studies, x-rays, photographs and surgery. The patient has the right to refuse any treatment, surgery or medical procedure.

Date __________________ Signature ________________________________** Relationship______________

**Authorization must be signed by the patient or by a parent, legal guardian or legal responsible party in the case of a minor or a patient who is physically or mentally incapable.