COASTAL FOOT & ANKLE SPECIALISTS

Patient Information

Last Name: _____ First Name: _____

Home Phone/Cell Phone: _____ Birth Date: _____ Sex: Male or Female

Address: _____

Out of State Address: _____

Email Address: _____ Pharmacy: _____

Marital Status: Single Married Widowed Who referred you here? _____

Primary Care Physician (PCP): _____ Date last seen by PCP: _____

What is your Foot/Ankle problem? _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone #: _____

Height: _____ Weight: _____

Past Medical History: Have you ever been diagnosed with any of the following?

☐ High Blood Pressure	Diabetes (A1C: _____)	Peripheral Vascular Disease
☐ Heart Disease	Peripheral Neuropathy	Varicose Veins
☐ Lung Disease	Arthritis	Bleeding/Clotting Disorder
☐ Kidney Disease	Gout	Anxiety/Depression
☐ Cancer _____	Other: _____	

Past Surgical History: _____

Allergies:

☐ No known drug allergies

☐ Iodine/Betadine Latex Adhesive/Tape Penicillin Lidocaine

☐ Other: _____

Social History:

Do you use tobacco products? Yes No Quit If yes, how much? _____

Do you drink alcohol? Yes No If yes, how much? _____

Medications: Please list and medications that you currently take, including over-the-counter.

_____	_____	_____
_____	_____	_____
_____	_____	_____