VALDOSTA FOOT AND ANKLE CLINIC, P.C.

Valdosta Foot and Ankle Surgery Center

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Patient Name _____ Date _____

Describe your foot problem in detail _____

_____

_____

How long have you had this problem? _____

Have you been treated for this condition before? Yes ☐ No ☐

Is your foot problem the result of an injury? Yes ☐ No ☐

If yes, please describe the circumstances of your injury: _____

_____

Injury occurred at: Home ☐ Work ☐ Auto Accident ☐ Other (describe) _____

Are you a diabetic? Yes ☐ No ☐ Is there a history of diabetes in your family? Yes ☐ No ☐

Please check any of the following you have had or now have:

_____ Heart Trouble	_____ Tuberculosis	_____ Epilepsy
_____ Gout	_____ Fainting	_____ Difficulty Healing
_____ Anemia	_____ Kidney Problems	_____ AIDS
_____ Shortness of Breath	_____ High Blood Pressure	_____ Hepatitis
_____ Arthritis	_____ Back Problems	_____ Liver Disease
_____ Phlebitis	_____ Swelling – Legs/Feet	_____ Stomach Disorder
_____ Foot Numbness	_____ Circulation Problems	_____ Ingrown Nails

Have you had any previous injuries or treatment to your feet or lower extremity? Yes ☐ No ☐

If yes, please describe _____

_____

_____

Do you smoke now? Yes ☐ No ☐ If yes, packs per day _____ How long? _____

Did you ever smoke? Yes ☐ No ☐ If yes, packs per day _____ How long? _____

When did you quit? _____

Please list the types of sports or physical activities you are active in _____

_____

Are you allergic to any medications? Yes ☐ No ☐

Please circle any known allergies:

Penicillin	Novocaine	Local Anesthetic
Codeine	Tape	Other Antibiotics (specify) _____
Aspirin	Sulfa Drugs	Other (specify) _____

_____
PATIENT SIGNATURE

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