WILES FOOT & ANKLE
PODIATRY DONE RIGHT

Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Email: _____

Please circle Yes or No.
If yes, please provide additional information as needed

Update Allergies

Do you have any allergies to drugs or foods? Yes No
If yes, please list them with their reaction:

_____
_____
_____
_____

Update Medications

If a prescription is called in or escribed, what is your preferred pharmacy and location:

_____
_____

May we contact your pharmacy to obtain your medication list? Yes No

If yes, please list all pharmacies with phone number or location so that we can extract your medication list from them. This includes mail order pharmacies.

_____
_____
_____

Update Family History

Mark an "X" under each condition that applies:

	Father	Mother	Son	Daughter	Brother	Sister
Anemia						
Anxiety						
Arthritis						
Asthma						
Enlarged Prostrate						
Back Problems						
Breast Cancer						
Heart Arteries Clogged						
Congestive Heart Failure						
Chronic Bronchitis or Emphysema						
Cancer						
High Cholesterol						
Dementia (memory loss)						
Depression						
Dermatitis (skin problem)						
Diabetes						
Epilepsy						
Heart Burn						
Glaucoma						
Gout						
HIV						
Headaches						
Hepatitis						
Hypertension						
Heart Attack						
Migraine Headaches						
Pneumonia						
Renal (kidney) stones						
Stroke						
Tuberculosis						
Thyroid disease						
Ulcer (stomach or intestine)						

Other Family Conditions

If there are conditions in the patient's Family History not listed above, please enter the family member and condition below.

_____
_____
_____
_____

Update Medical History

Circle all that apply:

Anemia	Yes	No	Epilepsy	Yes	No
Anxiety	Yes	No	Heartburn	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No
Asperger's disorder	Yes	No	Gout	Yes	No
Asthma	Yes	No	HIV Positive	Yes	No
Enlarged Prostrate	Yes	No	Headache	Yes	No
Back Problem	Yes	No	Hepatitis	Yes	No
Breast Cancer	Yes	No	Hypertension	Yes	No
Blocked Arteries	Yes	No	Hypertrophic Skin	Yes	No
Heart Failure	Yes	No	Heart Attack	Yes	No
Emphysema	Yes	No	Migrane Headaches	Yes	No
Cancer	Yes	No	Pneumonia	Yes	No
High Cholesterol	Yes	No	Kidney Stones	Yes	No
Dementia	Yes	No	Stroke	Yes	No
Depression	Yes	No	Thyroid Disease	Yes	No
Dermatitis	Yes	No	Stomach Ulcer	Yes	No
Diabetes	Yes	No			

If there are conditions in the Medical History not listed above, please enter them below:

_____
_____
_____
_____

Treating Physician for diagnoses listed above: _____

Update Social History

Tobacco information:
Light smoker is interpreted to mean less than 10 cigarettes per day, or an equivalent (but less concretely defined) quantity of cigar, pipe or chewing tobacco.
Heavy smoker is interpreted to mean greater than 10 cigarettes per day or an equivalent (but less concretely defined) quantity of cigar, pipe or chewing tobacco.

Tobacco History

Circle yes or no. If yes, please continue to explain:

Have you ever used cigarettes? **Yes** **No**
If yes, current every day some former user heavy light
Last date used: _____
Daily usage: _____
Years of use: _____ Quitting Attempts: _____ Quitting method: _____

Have you ever used cigars? **Yes** **No**
If yes, current every day some former user heavy light
Last date used: _____
Daily usage: _____
Years of use: _____ Quitting Attempts: _____ Quitting method: _____

Have you ever used pipe tobacco? **Yes** **No**
If yes, current every day some former user heavy light
Last date used: _____
Daily usage: _____ Packing: pouch tin
Years of use: _____ Quitting Attempts: _____ Quitting method: _____

Have you ever used chewing tobacco? **Yes** **No**
If yes, current every day some former user heavy light
Last date used: _____
Daily usage: _____ Packing: pouch tin pinch sachet
Years of use: _____ Quitting Attempts: _____ Quitting method: _____

Have you ever used dipping tobacco? **Yes** **No**
If yes, current every day some former user heavy light
Last date used: _____
Daily usage: _____ Packing: pouch tin pinch sachet
Years of use: _____ Quitting Attempts: _____ Quitting method: _____

Alcohol History

Alcohol Information:

Heavy alcohol use is defined at the following:
-Men over 65 and women – more than 7 standard drinks per week or more than 3 drinks per occasion
-Men 65 or younger – more than 14 standard drinks per week or more than 4 drinks per occasion

Have you ever consumed beer? Yes No
If yes, social occasional light heavy
Last date used: _____
Usage Number: _____ Packaging: Glass Bottle Can (per) day week month

Have you ever consumed wine? Yes No
If yes, social occasional light heavy
Last date used: _____
Usage Number: _____ Packaging: Glass Bottle (per) day week month

Have you ever consumed hard liquor? Yes No
If yes, social occasional light heavy
Last date used: _____
Usage Number: _____ Packaging: Glass Bottle (per) day week month

Updated Surgical History

Circle all that apply:

Abdominal Aortic Aneurysm Repair	Yes	No	Intestinal By-Pass	Yes	No
Aortic Aneurysm	Yes	No	Knee Arthroscopy	Yes	No
Appendectomy (Appendix)	Yes	No	Knee Surgery	Yes	No
Breast Augmentation (implants)	Yes	No	Lumbosacral Spine Surgery	Yes	No
Breast Reduction	Yes	No	Lasik Eye Surgery	Yes	No
Cardiac Artery Bypass Graft	Yes	No	Mastectomy	Yes	No
Removal of plaque from carotid artery	Yes	No	Ovary removal	Yes	No
Cataract Removal	Yes	No	Angioplasty of heart	Yes	No
Cesarean Section	Yes	No	Repair of leg/foot artery	Yes	No
Gall Bladder Surgery	Yes	No	Pacemaker Implanted	Yes	No
Removal of part of colon	Yes	No	Prostrate Biopsy	Yes	No
Stomach ulcer repair	Yes	No	Removal of prostrate	Yes	No
Lithotripsy for kidney stones	Yes	No	Shoulder Arthroscopy	Yes	No
Ectopic Pregnancy	Yes	No	Shoulder Surgery	Yes	No
Fracture Repair	Yes	No	Nasal sinus surgery	Yes	No
Gastric Banding surgery	Yes	No	Removal of spleen	Yes	No
Heart Valve implant	Yes	No	Enlarged Prostrate repair	Yes	No
Hernia repair	Yes	No	Removal of thyroid	Yes	No
Hip fracture repair	Yes	No	Tonsilectomy	Yes	No
Hip surgery	Yes	No	Tubal Ligation	Yes	No
Hysterectomy	Yes	No	Vasctomy	Yes	No

If there are conditions in the Surgical History not listed above, please enter them below:

_____

_____

_____

_____

Treating Physician for diagnoses listed above: _____