Erie Foot & Ankle center

Date:________________

Name:____

Sex: ☐ M ☐ F ☐ T Age:_____Height:__________Weight:_______Shoe Size:_______

Social Security Number:____

Birthdate:___________ Phone Number:____

Address:____

City:____State:_____________Zip:___________

Occupation:______________________Email:____

Primary Care Physician:____

How did you hear about Dr. Donovan?____

What foot or ankle concerns would you like addressed by your doctor today?

When did your condition begin?________________________Was it related to an injury?______

If so, what type of injury?____

What bothers you most about your foot or ankle? ____________________________________

Circle the scale to indicate your *average* pain due to your foot and ankle condition

0 1 2 3 4 5 6 7 8 9 10

No Pain Severe Pain

Have you tried any treatments for your foot and ankle condition?

____

List any surgical procedures:

1.______________________________________ 2.______________________________________

3.______________________________________ 4.______________________________________

erie Foot Ankle center

Allergies:____

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

List any medications:

1.____________________________________ 4.____________________________________

2.____________________________________ 5.____________________________________

3.____________________________________ 6.____________________________________

Pharmacy:_______________________Address:____________________Phone:__________

☐ Anemia	☐ High Blood Pressure	☐ Diabetes	☐ Blood Clots
☐ Gout	☐ Alcoholism	☐ Stroke	☐ Sleep Apnea
☐ Cancer	☐ AIDS/HIV	☐ Heart Condition	☐ Dialysis
☐ Osteoporosis	☐ Fibromyalgia	☐ Heart Attack	☐ Rheumatoid Arthritis
☐ Mental Illness	☐ Chronic Back Pain	☐ Irregular Heart Beat	☐ Stomach Ulcers
☐ Seizures	☐ Depression	☐ Asthma/Emphysema	☐ Hepatitis

Family History: ____

Pharmacy Name: ____

Pharmacy Phone Number:____

Pharmacy Address:____