Family Foot & Ankle Care
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PATIENT ASSESMENT FORM

Patient's name: _____ **Date**: _____

Please describe the foot/ankle problem(s) that you are currently experiencing:

_____

_____

On a pain scale what is the level of pain you are experiencing? (1-low level of pain 10-high level of pain)

1 2 3 4 5 6 7 8 9 10

Have you experienced any foot problems in the past? (circle) YES NO

Have you been previously treated for this condition? (circle) YES NO by PCP FOOT DR

CURRENT MEDICATIONS ____ NO KNOWN CURRENT MEDICATIONS

(Please list all current prescriptions, over the counter medications, vitamins, herbs, etc.)

Drug Name	Dose/Times per day	Drug Name	Dose/Times per day
_____		_____	
_____		_____	
_____		_____	
_____		_____	

PAST MEDICAL HISTORY: ____ NO KNOWN MEDICAL HISTORY

Please check ailments listed below:

____	DIABETES	____	HYPOTHYROIDISM	____	DEPRESSION
____	HEART DISEASE	____	KIDNEY DISEASE	____	LYME'S DISEASE
____	CONGESTIVE HEART FAILURE	____	HEPATITIS	____	FIBROMYALGIA
____	HYPERTENSION	____	BLEEDING DISORDER	____	OSTEOARTHRITIS
____	HIGH CHOLESTEROL	____	PITUITARY DISORDER	____	RHEUMATOID ARTHRITIS
____	HEART ATTACK	____	OSTEOPOROSIS	____	PVD
____	STROKE	____	CANCER	____	BLOOD CLOT/DVT/PE
____	CORONARY ARTERY DISEASE	____	PREGNANCY	____	SLEEP APNEA
____	RETINOPATHY	____	EPILEPSY/SEIZURES	____	ESOPHAGEAL REFLUX
____	URINARY TRACT INFECTION	____	ASTHMA	____	GOUT
____	SHORTNESS OF BREATH	____	COPD	____	EYE PROBLEMS

Other medical conditions: _____

ALLERGIES (to medications or other substances): YES NO

List allergies: _____

Type of reaction: _____

PAST SURGICAL HISTORY: ____ NO KNOWN SURGICAL HISTORY

Please list any operations and dates:

Name of surgery	Date of surgery
_____	_____
_____	_____
_____	_____

HOSPITALIZATIONS OTHER THAN FOR SURGERY: ____ NO KNOWN HOSPITALIZATIONS HISTORY

Please list any hospitalizations and dates:

Reason for Hospitalization	Date of Hospitalization
_____	_____
_____	_____
_____	_____

FAMILY HISTORY: ____ NO KNOWN FAMILY HISTORY

Family History:

Ailment	**Relationship**
Diabetes	_____
Cancer	_____
Heart Disease	_____
High Blood Pressure	_____
Respiratory Illness	_____
Stomach/Intestinal Problems	_____
Other_____	

SOCIAL HISTORY:

Occupation: _____

At work are you on your feet? NO YES _____% of the time on your feet

Marital status: (circle one) Married Single Divorced Separated Widowed

Education: (circle one for highest educational level achieved)

Elementary High School College Graduate Professional/Medical/Dental School

Are you a smoker?	YES	NO
If no, did you use it before?	YES	NO
Do you drink alcohol?	YES	NO
Do you use recreational drugs?	YES	NO

REVIEW OF SYSTEMS:

General

Trouble Sleeping	YES	NO	Change in Weight	YES	NO	Change in appetite	YES	NO
Fatigue	YES	NO	Fever	YES	NO	Headache	YES	NO
Weight Gain	YES	NO						

EYES

Eye pain	YES	NO	Dry Eyes	YES	NO	Visual changes	YES	NO
Bulging Eyes	YES	NO	Loss of Vision	YES	NO	Blurred Vision	YES	NO

MALE GU

Frequent urination	YES	NO	Prostate problems	YES	NO			

FEMALE GU

Date of LMP	___/___/____		Irregular periods	YES	NO	Hot flashes	YES	NO
Menopause	YES	NO	No. of pregnancies	____		Age of menstruation	____	

EARS/NOSE/MOUTH/THROAT

Sore throat	YES	NO	Hoarseness	YES	NO			
Problems snoring	YES	NO	Neck Pain	YES	NO			

ENDOCRINE

Thyroid problems	YES	NO	Excessive thirst	YES	NO	Increased shoe size	YES	NO
Excessive urination	YES	NO	Feeling cold	YES	NO	Feeling hot	YES	NO

RESPIRATORY

Cough	YES	NO	Shortness of Breath	YES	NO			

CARDIOVASCULAR

Carotid artery problem	YES	NO	Calf pain with walking	YES	NO	Ankle swelling	YES	NO
Shortness of breath	YES	NO	Heart palpitations	YES	NO	Chest pain	YES	NO

GASTROINTESTINAL

Indigestion	YES	NO	Appetite change	YES	NO	Abdominal Pain	YES	NO
Constipation	YES	NO	Diarrhea	YES	NO	Swallowing difficulty	YES	NO
Nauseau/vomiting	YES	NO						

HEMATOLOGIC/LYMPHATIC

Anemia	YES	NO	Easy bruising/bleeding	YES	NO			
Enlarged glands	YES	NO	Lymphedema	YES	NO			

MUSCULOSKELETAL

Muscle pain/cramps	YES	NO	Joint stiffness	YES	NO			
Rheumatoid arthritis	YES	NO	Shakes/tremors	YES	NO			

SKIN

Hair loss	YES	NO	Dryness	YES	NO	Feet ulcers	YES	NO
Itching	YES	NO	Skin color changes	YES	NO	Skin rash	YES	NO

NEUROLOGICAL

Numbness/tingling in feet	YES	NO	Weakness in legs	YES	NO			
History of head injury	YES	NO	Burning in feet at night	YES	NO			
Seizures	YES	NO	Headaches	YES	NO			

PSYCHIATRIC

Depression	YES	NO	Irritability	YES	NO	Anxiety	YES	NO
Insomnia	YES	NO	Memory loss/confusion	YES	NO			

I authorize the release of all medical information necessary to process claims, including by electronic means if available and request benefits be paid to Dr. Caswell. I do understand that I am responsible to pay my deductible, co-payment, and any charge for non-covered services. I also acknowledge that all above medical information is accurate and up to date to the date of service today.

Signature_____

Electronic Prescription Authorization

I, the undersigned certify that I grant permission to Philip C. Caswell, D.P.M. / Family Foot & Ankle Care to electronically prescribe and view my prescription history from external sources in relation to medical services provided.

Signature _____ Date ___/___/___