Soffer Foot and Ankle Care, L.L.C.
NEW PATIENT HISTORY FORM

Date:_____ Patient name:_____ Age: _____ DOB: _____

PODIATRIC HISTORY: Please indicate your foot problems and diagnoses:	
☐Yes ☐No	Fungal toenails
☐Yes ☐No	Athlete's foot
☐Yes ☐No	Ingrown toenails
☐Yes ☐No	Corns and calluses
☐Yes ☐No	Numbness or tingling in feet or legs
☐Yes ☐No	Foot or leg cramps
☐Yes ☐No	Heel pain (plantar fasciitis)
☐Yes ☐No	Ankle pain
☐Yes ☐No	Foot or ankle swelling
☐Yes ☐No	Plantar warts
☐Yes ☐No	Chronic wound
☐Yes ☐No	Bunion
☐Yes ☐No	Neuroma
☐Yes ☐No	Hammertoe
☐Yes ☐No	Flat feet
☐Yes ☐No	Diabetic foot
☐Yes ☐No	Gout
☐Yes ☐No	Other:
Please indicate if you have any of these symptoms:	
☐Yes ☐No	Fevers
☐Yes ☐No	Chills
☐Yes ☐No	Nausea/Vomiting
☐Yes ☐No	Leg discoloration
☐Yes ☐No	Chest Pain
☐Yes ☐No	Shortness of Breath
☐Yes ☐No	Leg swelling
☐Yes ☐No	Leg pain

Reason for your visit: _____
_____
_____
_____
_____

Preferred phone number to call with test results:
_____
Ok to leave a message? _____

Do you currently smoke or use tobacco products? _____
If so, how many packs per day? _____
For how many years? _____

Have you quit smoking? _____
When did you quit? _____
How many packs/day did you to smoke? _____
For how many years? _____

Do you drink alcohol? _____
If so, how many drinks per week? _____

Do you use heroin, cocaine, methamphetamines, or other recreational drugs? _____

Occupation? _____

Do you exercise? _____
If so, how many times per week? _____
How many minutes each time? _____
What kind of exercises? _____

Do you live alone? _____
If not, who lives with you? _____

Have you ever seen any of the following specialists? If so, please list name, date seen, and treatment:

	Specialist:	Name:	Date last seen:	Treatment recommended:
☐Yes ☐No	Primary care physician			
☐Yes ☐No	Podiatrist			
☐Yes ☐No	Vascular surgeon			
☐Yes ☐No	Infectious disease			
☐Yes ☐No	Endocrine (diabetes)			
☐Yes ☐No	Neurologist			

Please check if you have had the following treatments for your feet before:

Treatment:	Start Date:	Duration:	Type/Comment:
☐ Antibiotics			
☐ Topical care			
☐ Hospitalization			
☐ Surgery			
☐ X-rays			
☐ MRI			
☐ Other:			

SURGICAL HISTORY:				
Disease/Diagnosis/Injury	Procedure or surgery	Date	Physician	Hospital

MEDICAL HISTORY: Please indicate if you have been diagnosed with any of the conditions listed	
☐Yes ☐No	Diabetes Type I
☐Yes ☐No	Diabetes Type II
☐Yes ☐No	Peripheral artery disease (poor circulation)
☐Yes ☐No	Venous disease
☐Yes ☐No	Peripheral neuropathy (poor sensation)
☐Yes ☐No	Blood clots
☐Yes ☐No	Kidney disease
☐Yes ☐No	Stomach or intestinal problems
☐Yes ☐No	Asthma or COPD
☐Yes ☐No	Heart disease
☐Yes ☐No	High blood pressure
☐Yes ☐No	High cholesterol
Other:	

ALLERGIES:
☐ None
☐ Adhesive/ Tape
☐ Ibuprofen
☐ Penicillin
☐ Sulfa drugs
☐ Latex
☐ Iodine
☐ Other:

Please indicate any family members (parent, sibling, grandparent, or child) with the following conditions:			
	Condition	Relationship to you:	Age at diagnosis:
☐Yes ☐No	Diabetes		
☐Yes ☐No	Blood clots		
☐Yes ☐No	Stroke		
☐Yes ☐No	Heart Attack		

MEDICATIONS: (If you have a list, please attach)				
NAME	DOSE	ROUTE	FREQUENCY	REASON

To be filled out by medical staff:

BP_____ Pulse _____ Temp_____ Weight _____ Height_____