Prairie View Foot & Ankle LLC

Sarah Russell, DPM
5401 College Blvd. Ste. #204
Leawood, KS 66211

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Date Last Seen: _____

Height: _____ Weight: _____ Shoe Size: _____

Chief Concern

Reason for today's visit? _____

Is your current problem due to an injury? If so, when and where? _____

How long has this problem been present? _____

From 1 to 10 what is the level of your pain? (1 is low, 10 is high) _____

Does anything improve this problem? _____

Does anything worsen this problem? _____

What treatments have your tried? _____

Have you seen a podiatrist or other physician for this problem? _____

Have you seen a podiatrist for any other problems? If so, what? _____

Medical History

Please **CHECK** any current or past conditions

___ Alcoholism	___ High Cholesterol
___ Anemia	___ HIV/AIDS
___ Anorexia	___ Kidney Disease
___ Appendicitis	___ Liver Disease
___ Arthritis	___ Measles
___ Asthma	___ Migraines
___ Bleeding Disorder	___ Miscarriage
___ Bronchitis	___ Mononucleosis
___ Cancer	___ Multiple Sclerosis
___ Cataracts	___ Mumps
___ Chemical Dependency	___ Pacemaker
___ Chicken Pox	___ Pneumonia
___ CHF	___ Polio
___ Coronary Disease	___ Prostate Problem
___ COPD	___ Psychiatric Care
___ Dementia	___ Rheumatic Fever
___ Diabetes	___ Scarlet Fever
___ Emphysema	___ Seizures
___ Epilepsy	___ Stroke
___ Gout	___ Suicide Attempt
___ Heart Attack	___ Thyroid Problems
___ Heart Disease	___ Tonsillitis
___ Hepatitis	___ Tuberculosis
___ Hernia	___ Typhoid Fever
___ High Blood Pressure	___ Ulcers

___ Other_____

Medication List

Please list **ALL** medications: Prescribed, Over-the-Counter, Vitamins and/or Supplements **OR** attach medication list

Medication Name	Dosage	Frequency

Allergies/Sensitivities

Please list **ALL** allergies/sensitivities and reaction to each

Allergy To	Reaction

Surgical History & Hospitalizations

Year	Procedure and/or Reason

Social History

Please CIRCLE and/or ANSWER what applies to you

I am…..... SINGLE MARRIED WIDOWED
SEPARATED DIVORCED

I live with _____

Smoker? CURRENT, I smoke ____ pack(s) per day
FORMER, I quit_____ years ago
NEVER

Do you drink alcohol? YES, I have _____drinks per week
NO

Do you drink caffeine? YES, I have _____drinks per day
NO

Do you use any recreational drugs? YES NO

Are you currently employed? YES NO

Do you have children? YES, I have _____ children
NO

Are you currently pregnant? YES NO

Family History

Does anyone in your family have history of the following? If YES, check and list who (Mother, Father, Siblings, Children)

___ Arthritis:_____ ___COPD:_____ ___Heart Attack:_____ ___Mental Illness:_____

___Asthma:_____ ___Diabetes:_____ ___Heart Disease:_____ ___Stroke:_____

___Cancer:_____ ___Glaucoma:_____ ___High Blood Pressure:_____ ___Tuberculosis:_____

___Chemical Dependency: ___Gout:_____ ___Kidney Disease:_____ ___Other:_____

_____

Review of Systems

Please CHECK any symptom you *have currently or had within the past year*

Constitutional
__Recent Fevers/Sweats

Cardiovascular
__Blood Clots
__Poor Circulation
__Swelling of Ankles
__Varicose Veins
__Venous Insufficiency

Endocrine
__Cuts take longer to heal
__Extreme Thirst
__Hyperglycemia
__Hypoglycemia

Neurological
__Neuropathy

Allergic/Immunologic
__Gouty Attack

Psychiatric
__Depression

Musculoskeletal
__Arthritis
__Fracture:_____
__Joint Pain:_____

Skin
__Bruise Easily
__Cellulitis
__Chronic Wounds
__Itching
__Rash

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____