WAUKESHA FOOT SPECIALISTS
P: (262) 544-0700
F: (262) 544-9017
20700 Watertown Road Suite 200
Waukesha, WI 53186

Today's Date _____

Name _____ DOB _____ Sex M F SSN _____

Marital Status Single Divorced Married Race _____ Ethnicity _____ Language _____

Email _____ Phone _____

Address _____ City_____ State _____ Zip _____

Emergency Contact: Name_____ Phone _____ Relationship_____

If Patient is a **MINOR** (under 18 years old) please fill out guardian information below

Guardian Name_____ Phone _____ Relationship_____

How would you like to receive appointment reminders? Phone call Text Message Preferred # _____

Who can we leave messages with?_____

How did you find out about our practice? Physician Friend Family Member Online Other _____

Primary Care Physician _____ Phone _____ Date last seen _____

Height _____ Weight _____ Shoe Size _____ Type of shoe most commonly worn _____

History of Present Illness

Reason for visit _____

Pain Level (1-10) ____ /10 Describe your pain _____

When did this start? _____ Onset: SUDDEN GRADUAL Trauma/Injury related? YES NO

Problem is: CONSTANT ON/OFF When do you typically notice your problem? _____

Problem is: WORSENING IMPROVING STAYING THE SAME

What treatments have you tried? Have they worked? _____

Social History

Do you Smoke? YES NO If YES, how many packs per day? _____ For how long? _____ Quit Date _____

Alcohol Intake? None/Never Social / Occasional Most Days Everyday

Occupation _____ % time spend standing _____

Regular exercise? YES NO If YES, please describe _____

Allergies

Please specify allergy and reaction

☐ NO KNOWN DRUG ALLERGIES

Name _____Reaction _____ Name _____Reaction _____

Name _____Reaction _____ Name _____Reaction _____

Medications

I take the following Medications:

☐ I Do Not Take Any Medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical History/Problems

☐ ADHD	☐ Alcoholism	☐ Allergies	☐ Anemia	☐ Anxiety
☐ Arthritis	☐ Asthma	☐ Back Problem	☐ Blood Clots	☐ BPH
☐ Blood Disorder	☐ Breast Cancer	☐ CAD	☐ Cancer	☐ CHF
☐ Cholesterol (high)	☐ Circulation disorder	☐ COPD	☐ CVA	☐ Dementia
☐ Depression	☐ Dermatitis	☐ Diabetes	☐ DVT	☐ Epilepsy
☐ GERD	☐ Glaucoma	☐ Gout	☐ Headache	☐ Heart Disease
☐ Hepatitis	☐ HIV	☐ Hypertension	☐ Kidney Disease	☐ Kidney stones
☐ Liver disease	☐ Mental Illness	☐ MI	☐ Migraine	☐ Neuropathy
☐ Pneumonia	☐ Skin Disorder	☐ Sleep Apnea	☐ Stomach/bowel	☐ Stroke
☐ TIA	☐ Tuberculosis (TB)	☐ Ulcers	☐ Other (please explain below)	

Other _____

Are you Pregnant? YES NO Are you nursing? YES NO

Surgical History

Please list procedure and approximate date/year

☐ NONE
☐ Appendectomy _____
☐ C-Section _____
☐ Other _____
☐ Angioplasty _____
☐ Bypass _____
☐ Cholecystectomy (gallbladder) _____
☐ Foot/Ankle Surgery _____

Artificial Heart Valve?
YES NO
Artificial Joints?
YES NO If YES, please describe_____

Family History

Please list any blood relative/family history of disease and note the family member

☐ NONE
☐ Dementia _____
☐ Depression _____
☐ Heart Disease _____
☐ Hypertension_____
☐ Strokes _____
☐ Blood Clots _____
☐ Diabetes _____
☐ Cancer _____
☐ High Cholesterol _____
☐ Neurological _____
☐ Other _____

Review of Systems *please check if you are currently experiencing these symptoms, otherwise check "NONE"*

Constitutional

☐ Chills ☐ Decline in Health ☐ Fatigue ☐ Fever ☐ Weakness ☐ NONE
☐ Weight Gain ☐ Weight Loss

Respiratory

☐ Asthma ☐ Bronchitis ☐ COPD ☐ Cough ☐ Pleurisy ☐ NONE
☐ Shortness of Breath ☐ TB ☐ Wheezing

Cardiovascular

☐ Chest pain ☐ Cold hands/feet ☐ Cool Extremities ☐ Fainting ☐ Fever
☐ High Blood Pressure ☐ Leg Pain with Walking ☐ Leg Swelling ☐ Palpitations ☐ Varicose Veins ☐ NONE

Gastrointestinal

☐ Antacids ☐ Constipation ☐ Diarrhea ☐ Thirst ☐ Gall Bladder Dz
☐ Heartburn ☐ Hemorrhoids ☐ Hepatitis ☐ Jaundice ☐ Laxatives ☐ NONE
☐ Liver dz ☐ Nausea ☐ Rectal bleed ☐ Swallowing Problems

Musculoskeletal

☐ Ankle sprain ☐ Arch Pain ☐ Arthritis ☐ Back Problems
☐ Broken ankle ☐ Broken foot ☐ Bunions ☐ Calluses
☐ Childhood foot problems ☐ Corns ☐ Flat feet ☐ Gait problems
☐ Gout ☐ Hammer toe ☐ Heel pain ☐ High arches ☐ NONE
☐ In toeing ☐ Joint implants ☐ Joint pain ☐ Joint stiffness
☐ Knee pain ☐ Lower back pain ☐ Muscle cramps ☐ Muscle stiffness
☐ Neuroma ☐ Orthotic use ☐ Paralysis ☐ Restricted motion
☐ Shoe insert use ☐ Toe walking ☐ weakness

Skin

☐ athlete's foot ☐ dryness ☐ eczema ☐ fungal nails ☐ hives ☐ ingrown nail
☐ itching ☐ keloid scar ☐ lumps ☐ mole changes ☐ rash ☐ warts ☐ NONE

Neurological

☐ black outs ☐ burning ☐ charcot neuropathy ☐ fainting ☐ neuromas
☐ numbness ☐ speech disorder ☐ strokes ☐ tingling ☐ tremors ☐ NONE
☐ unsteady gait

Hematologic/Lymph

☐ Anemia ☐ Bleeding easily ☐ Blood clots ☐ Easy bruising ☐ Recent chemotherapy
☐ Slow healing ☐ Swollen glands ☐ Transfusion reaction ☐ NONE

Genitourinary - Urinary

☐ Blood in urine ☐ Burning ☐ Excessive urination ☐ Flank pain ☐ Incontinence
☐ Infections ☐ Kidney stones ☐ Retention ☐ urgency ☐ NONE

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPPA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____