

VASCULAR & DIABETIC FOOT CENTER

Patient Name: _____ DATE OF BIRTH: _____

INITIAL PATIENT FORM

Reason for your visit: _____ Visit Date: _____

CIRCLE AREA(S) OF CONCERN:

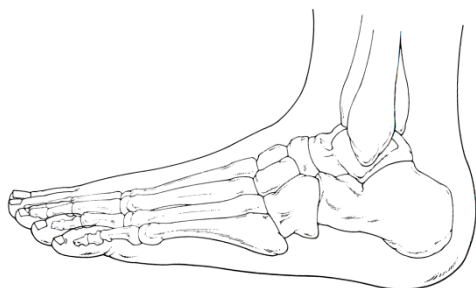
Left



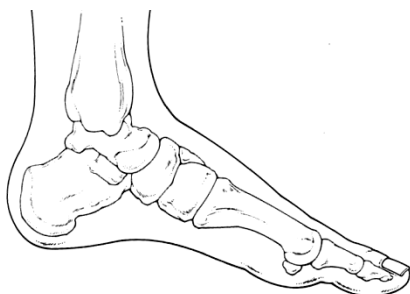
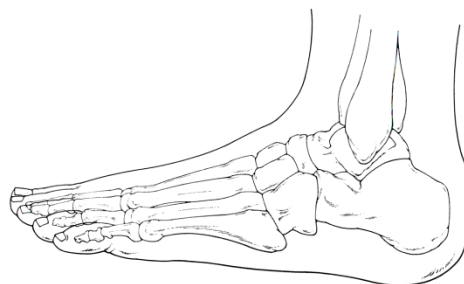
Right



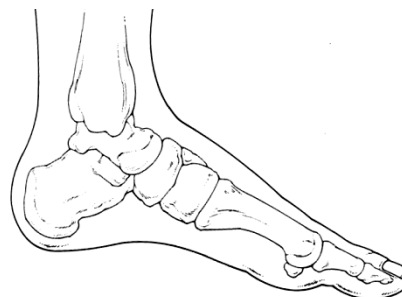
TOP/BOTTOM



OUTSIDE



INSIDE



Type of pain:

- | | | | |
|-----------------------------------|--|---|------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Soreness | <input type="checkbox"/> Tightness |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Numbness | <input type="checkbox"/> Aching | <input type="checkbox"/> Pressure |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Tingling | <input type="checkbox"/> Throbbing | |
| <input type="checkbox"/> Pulling | <input type="checkbox"/> Radiating | <input type="checkbox"/> Cramping | |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Electric shocks | <input type="checkbox"/> Pins & needles | |

Pain Level (0-10): _____

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Patient Name: _____ DATE OF BIRTH: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

LIST OF TREATING PHYSICIANS (other than Primary Care and Referring):

_____ Name	_____ Specialty
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_____ Name	_____ Specialty
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_____ Name	_____ Specialty
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_____ Name	_____ Specialty
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_____ Name	_____ Specialty
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_____ Name	_____ Specialty
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_____ Name	_____ Specialty
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_____ Name	_____ Specialty
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_____ Name	_____ Specialty
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_____ Name	_____ Specialty
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PHARMACY Name: _____

Street Address: _____

City: _____ Phone: _____

HOME HEALTH Name: _____

AGENCY: Street Address: _____

City: _____ Phone: _____

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CURRENT MEDICATIONS including over-the-counter & supplements:

☐ Provided attached list

[illegible]

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PAST MEDICAL HISTORY (e.g. diabetes mellitus, hypertension, hypercholesterolemia, etc.):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST SURGICAL HISTORY (e.g. appendectomy, tonsillectomy, etc.) including date(s):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DRUG ALLERGIES / REACTIONS (name & reaction):

☐ No Known Drug Allergies

_____	_____
_____	_____
_____	_____
_____	_____

FAMILY (not personal) HISTORY:

(Mother, Father, Sibling, etc.)

☐ Adopted – No known family history

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Arterial Disease _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Kidney Disease _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Lung Disease _____	<input type="checkbox"/> Heart Attack _____
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Mental Illness _____	<input type="checkbox"/> Other _____

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Patient Name: _____ DATE OF BIRTH: _____

SOCIAL HISTORY:

Tobacco Use:

☐ Current every day smoker: Year started: _____ ☐ Cigarettes: _____ per day ☐ Cigars: _____ per day

☐ Former Smoker: Year quit: _____

☐ Never Smoker

☐ Smokeless Tobacco: Year started: _____ Type _____ Amount per day _____

☐ Nicotine gum or patch: Amount per day _____

☐ Electronic Cigarettes: Year started: _____ Amount per day _____

Caffeine Use: ☐ Yes ☐ No Type _____ Cups per day _____

Alcohol Use: ☐ Yes ☐ No Type _____ Amount per day _____

Substance Abuse: ☐ Yes ☐ No Substance (e.g. cocaine, marijuana) _____

Illicit Drug Use: ☐ Yes ☐ No Drug (e.g. OxyContin, Hydrocodone) _____

Marital Status: _____ # Children: _____ Occupation: _____

Lives in (e.g. home, apartment): _____ Lives with (e.g. no one, spouse): _____

Cultural, Religious, or Language Concerns: _____

ADVANCED DIRECTIVES AND INSTRUCTIONS:

Advanced Directives: _____ ☐ Do not resuscitate

Durable power of attorney for healthcare: _____

FALL RISK ASESMENT:

History of Falling: ☐ Yes ☐ No

Secondary Diagnosis (have more than 1 medical diagnosis): ☐ Yes ☐ No

Aids for walking: ☐ none/wheelchair/bed rest ☐ crutches/cane/walker ☐ furniture (use for support)

IV or IV Access: ☐ Yes ☐ No Gait: ☐ normal / wheelchair / bed rest ☐ weak ☐ impaired

Mental Status: ☐ oriented/understand own ability ☐ overestimate or forget limitations

Have you experienced or more falls without injury within past year: ☐ Yes ☐ No

Have you experienced any fall with injury within past year: ☐ Yes ☐ No

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<p>Constitutional: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> chills <input type="checkbox"/> fatigue <input type="checkbox"/> fever <input type="checkbox"/> loss of appetite <input type="checkbox"/> marked weight change <input type="checkbox"/> night sweats <input type="checkbox"/> weight gain <input type="checkbox"/> unintentional weight loss <input type="checkbox"/> weakness <input type="checkbox"/> other: _____ <p>Eyes: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> blurred vision <input type="checkbox"/> discharge/drainage <input type="checkbox"/> double vision/spots/flashing lights <input type="checkbox"/> dry eyes <input type="checkbox"/> excessive tearing <input type="checkbox"/> eye pain <input type="checkbox"/> glasses/ contacts <input type="checkbox"/> partial/complete blindness <input type="checkbox"/> sensitivity to light <input type="checkbox"/> vision changes <input type="checkbox"/> other: _____ <p>Ears/Nose/Mouth/Throat: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> bleeding gums <input type="checkbox"/> current infection <input type="checkbox"/> dental problems <input type="checkbox"/> difficulty clearing ears <input type="checkbox"/> bad breath <input type="checkbox"/> hearing loss/aid <input type="checkbox"/> hoarseness <input type="checkbox"/> ear pain <input type="checkbox"/> frequent colds <input type="checkbox"/> loss of smell <input type="checkbox"/> loss of taste <input type="checkbox"/> nasal congestion <input type="checkbox"/> nose bleeds <input type="checkbox"/> earache <input type="checkbox"/> painful/swollen lymph nodes <input type="checkbox"/> post nasal drip <input type="checkbox"/> sore throat <input type="checkbox"/> other: _____ <p>Cardiovascular: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> chest pain <input type="checkbox"/> profuse sweating <input type="checkbox"/> difficulty breathing on exertion <input type="checkbox"/> edema <input type="checkbox"/> leg pain when walking <input type="checkbox"/> leg resting pain <input type="checkbox"/> leg swelling <input type="checkbox"/> difficulty breathing laying down <input type="checkbox"/> palpitations <input type="checkbox"/> fainting <input type="checkbox"/> other: _____ 	<p>Gastrointestinal: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> acid reflux <input type="checkbox"/> bloody stools <input type="checkbox"/> bowel incontinence <input type="checkbox"/> change in bowel habits <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> hemorrhoids <input type="checkbox"/> indigestion <input type="checkbox"/> jaundice <input type="checkbox"/> loss of appetite <input type="checkbox"/> nausea / vomiting <input type="checkbox"/> rectal bleeding <input type="checkbox"/> stomach/abdominal pain <input type="checkbox"/> vomiting of blood <input type="checkbox"/> other: _____ <p>Genitourinary: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> abnormal vaginal bleeding <input type="checkbox"/> bladder spasm <input type="checkbox"/> blood in urine <input type="checkbox"/> decreased force in stream <input type="checkbox"/> urinary infrequency <input type="checkbox"/> voiding multiple times at night <input type="checkbox"/> painful urination <input type="checkbox"/> pregnant <input type="checkbox"/> urinary incontinence <input type="checkbox"/> other: _____ <p>Integumentary: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> change in hair, skin, nails <input type="checkbox"/> skin dryness <input type="checkbox"/> calluses/corns <input type="checkbox"/> change in mole appearance <input type="checkbox"/> itching <input type="checkbox"/> lesions <input type="checkbox"/> lumps <input type="checkbox"/> prone to skin tears <input type="checkbox"/> rash <input type="checkbox"/> skin allergies <input type="checkbox"/> sun sensitivity <input type="checkbox"/> other: _____ <p>Endocrine: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> cold intolerance <input type="checkbox"/> heat intolerance <input type="checkbox"/> excessive thirst <input type="checkbox"/> excessive hunger <input type="checkbox"/> excessive urination <input type="checkbox"/> other: _____ 	<p>Musculoskeletal: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> assistive devices: _____ <input type="checkbox"/> backache <input type="checkbox"/> contractures <input type="checkbox"/> decreased activity <input type="checkbox"/> deformities <input type="checkbox"/> joint pain <input type="checkbox"/> joint swelling <input type="checkbox"/> muscle pain <input type="checkbox"/> muscle wasting <input type="checkbox"/> muscle weakness <input type="checkbox"/> other: _____ <p>Neurologic: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> abnormal gait <input type="checkbox"/> dizziness <input type="checkbox"/> headaches <input type="checkbox"/> loss of sensation to feet <input type="checkbox"/> memory loss <input type="checkbox"/> numbness <input type="checkbox"/> one-sided weakness <input type="checkbox"/> paralysis <input type="checkbox"/> seizures <input type="checkbox"/> spasms <input type="checkbox"/> tingling <input type="checkbox"/> tremors <input type="checkbox"/> weakness <input type="checkbox"/> other: _____ <p>Hematologic/Lymphatic: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> bruising easily <input type="checkbox"/> bleeding/clotting disorders <input type="checkbox"/> bleeding tendency <input type="checkbox"/> blood transfusions <input type="checkbox"/> enlarged lymph nodes <input type="checkbox"/> swelling <input type="checkbox"/> swollen glands <input type="checkbox"/> other: _____ <p>Allergic/Immunologic: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> frequent rashes <input type="checkbox"/> hay fever <input type="checkbox"/> hives <input type="checkbox"/> runny nose <input type="checkbox"/> recurrent fevers <input type="checkbox"/> other: _____ <p>Psychiatric: <input type="checkbox"/> None</p> <ul style="list-style-type: none"> <input type="checkbox"/> anxiety <input type="checkbox"/> claustrophobia <input type="checkbox"/> insomnia <input type="checkbox"/> nervousness/tension <input type="checkbox"/> restraints <input type="checkbox"/> suicidal <input type="checkbox"/> memory loss <input type="checkbox"/> depression <input type="checkbox"/> other: _____
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