



DR. SCOTT O'CONNOR

Fellow, American College of Foot & Ankle Surgery
 Diplomate, American Board of Podiatric Surgeons
 Certified in Foot, Reconstructive Rearfoot/Ankle Surgery

Name _____ Today's Date _____ Age _____ Weight _____ lb Height _____ Shoe Size _____

Family physician _____ Date Last Seen _____ Doctor's Address _____

Specialist _____ For What Condition _____ Do/Have you had Orthotics or Diabetic Shoes? _____

What kind of Foot/Ankle Problem? Right _____ Left _____
 _____ For How Long? _____

Review of Symptoms

Do you have an excessive: Thirst? Yes/no Hunger? Yes/no Urination? Yes/no
 Any difficulties healing cuts or infection? Yes/no Explain _____

Do you bleed easily or on a **blood thinner**? Yes/no Explain _____

Do you have a stomach **ulcer**? Yes/no Is there active bleeding? Yes/no

Have you had problems with: (please check all that apply)

- | | | | | |
|--------------------|-------------------|--------------|--------------|------------------|
| ___ Skin/Hair | ___ Eyes/Ears | ___ Heart | ___ GI Tract | ___ Blood |
| ___ Bladder/Kidney | ___ Bleeding | ___ Muscle | ___ Gout | ___ Seizure |
| ___ Neurological | ___ Stroke | ___ Bleeding | ___ Clotting | ___ Heart Attack |
| ___ Extremities | ___ Liver Disease | ___ Kidney | ___ DVT | ___ Anesthesia |

If you checked any of the above, please explain further: _____

Past Medical History

Current Medications-Name/Dosage/Frequency See Attached List

- | | | | |
|---------|---------|---------|---------|
| 1 _____ | 2 _____ | 3 _____ | 4 _____ |
| 5 _____ | 6 _____ | 7 _____ | 8 _____ |

Any **medical** problems or diseases? _____

Any **allergic** reactions to: 1. Medications? Yes/no 2. Iodine? Yes/no 3. Tape? Yes/no

Please Explain? _____

Are you **Diabetic**? Yes/no If yes, how is it controlled? _____

Past Family History

Any significant family medical history? _____

Which member of your family? Mother _____ Father _____ Brother _____ Sister _____ Other _____

Social History

Do/Did you smoke? Yes/no How Much? _____ How Long? _____

Do/Did you drink? Yes/no How Much? _____ How Long? _____

Any addictions to: Drugs? Yes/no Alcohol? Yes/no Painkillers? Yes/no

Surgical History

Have you had any surgeries? Yes/no Explain? _____

Have you or family had a reaction to anesthesia? Yes/no Explain? _____

Have you had heart valve or joint replacement? Yes/no Explain? _____

Is there any pertinent conditions not previously mentioned? Yes/no Explain? _____