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ALPINE FOOT
SPECIALISTS

Anna C. Gurrera,D.P.M.

NAME:_____ **DOB:**_____

What brings you in today? _____

Vital Sign: **Height:** _____ **Weight:** _____ **Blood Pressure:** _____ **Shoe Size:** _____

Surgical/ Injury History:

List the type of surgery and date: _____

_____

List any injuries that required medical attention or hospitalization and the date:

_____

_____

Social History (Circle one for each that apply below)
Are you Pregnant: Yes / No

Tobacco Use: Everyday Smoker / Occasional Smoker / Former Smoker / Never Smoked

Year started smoking: _____ Year Quit: _____

Alcohol Use: How many drinks per week? _____ History of alcoholism? Y/N History of drug use? _____

Medical History (Circle all that apply)

Anemia Arthritis (Osteoarthritis) Arthritis (Rheumatoid) Asthma Blood Disorder Back Pain Cancer Blood Clots COPD Gout Heart Disease Hepatitis (B or C) HIV+/AIDS High Blood Pressure Reflux Kidney Disease Neurological Disorder Seizures Strokes Thyroid Problem Stomach Ulcers

Diabetes – Last Blood Sugar _____ **AIC**_____

Last date seen General Physician: _____ **Last date seen Eye Doctor:** _____

Other: _____

TURN TO THE BACK PLEASE ➡

Family History (Circle all that apply)

Alcoholism Asthma Blood Disorder Cancer Diabetes Heart Disease Hepatitis High Blood Pressure Kidney Disease

Neurological Disease Seizures Strokes Thyroid Problem

Foot Issues: _____ Other: _____

Medication List (list all current medication and dosages – including non-prescription/over the counter medication) _____

_____

_____

Pharmacy

What is your preferred pharmacy?

Name _____ Phone _____

Address _____

Allergies – Medication / Environmental (Circle all that apply)

☐ No Known Allergies Penicillin Sulfa Tetracycline Codeine Adhesive Tape Latex Iodine/Betadine/Shellfish

Radiographic Dyes Non-Steroidal Anti-inflammatories (Advil,Motrin,Aleve)

_____ _____

Signature of patient, guarantor, or responsible party **Relationship to patient**

_____ _____

Print name of person whose signature appears **Date**

65 Years Old and Over Questionnaire

Do you have a do-not-resuscitate (DNR) care plan? Yes/No

Have you fallen in the past year? Yes/No

I understand the information on this form is essential to determine my medical needs and the provision of treatment. I understand that if any changes occur in my medical history/health, I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and I will not hold any staff member responsible for any errors that I have made in the completion of this form.