

Ocean County Foot & Ankle Surgical Associates, P.C.

Patient Questionnaire

Name: _____ Date: _____

Chief Complaint: _____

Past Medical History: Do you suffer from any of the following:

	No	Yes		No	Yes
Diabetes (Problems with blood sugar)	[]	[]	Kidney disorders	[]	[]
Congestive heart failure	[]	[]	Gastrointestinal disorders	[]	[]
Angina (chest pain)	[]	[]	Tuberculosis	[]	[]
Previous heart attack-When_____	[]	[]	Sleep apnea	[]	[]
Heart murmur	[]	[]	Arthritis:	[]	[]
High blood pressure	[]	[]	If yes Rheumatoid	[]	[]
High cholesterol	[]	[]	Osteo	[]	[]
Stroke	[]	[]	Lupus	[]	[]
Cancer	[]	[]	Sarcoidosis	[]	[]
Seizures	[]	[]	Hepatitis, cirrhosis, liver disease	[]	[]
Bleeding disorders	[]	[]	Back or neck problems	[]	[]
Thyroid disorders	[]	[]	Difficulty with anesthesia	[]	[]
Asthma	[]	[]	Glaucoma	[]	[]
Emphysema	[]	[]	Cataracts	[]	[]
Migraine headaches	[]	[]	Rheumatic fever	[]	[]
Blood Clots or DVT	[]	[]	Depression	[]	[]
Other: _____			Prostate problems	[]	[]
			Sickle Cell	[]	[]

Past Surgical History:

Please list any surgery that you have had:	No	Yes	
Heart bypass surgery	[]	[]	
Carotid surgery	[]	[]	
Appendectomy	[]	[]	
Gall bladder surgery	[]	[]	
Foot/Ankle surgery	[]	[]	<i>If so, specify</i> _____
Other: _____			

Have you ever had radiation treatment: [] []

Allergies:

Do you have allergies to medications:	No	Yes
Please Specify: _____		
Latex	[]	[]
Shellfish	[]	[]
X-ray contrast	[]	[]

History Reviewed By Doctor : _____

Medications:

Please list all medications that you currently take:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Do you currently take:

	No	Yes
Aspirin	[]	[]
Ginkgo Biloba	[]	[]
Motrin/Ibuprofen/Advil	[]	[]
Other herbal preparations: _____		

Social History:

	No	Yes
Do you now, or have you ever smoked:	[]	[]
If yes, how many years? _____		
If yes, how much do you smoke per day? _____		
If you no longer smoke, when did you quit? _____		

Do you drink alcohol?	[]	[]
If so, how much daily or weekly? _____		

Do you drink:	No	Yes
Coffee	[]	[] How much a day? _____
Soda with caffeine	[]	[] How much a day? _____
Tea	[]	[] How much a day? _____

Family History:

	No	Yes	Who?
Has anyone in your family ever suffered from any of the following?			
Bleeding problems	[]	[]	_____
Cancer	[]	[]	_____
Diabetes	[]	[]	_____
Heart disease	[]	[]	_____
Hypertension	[]	[]	_____
Thyroid disorders	[]	[]	_____
Other _____	[]	[]	_____

Do you have a Living Will? (for patients 18 yrs. & above)	[]	[]
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Do you or your caregiver have any of the following barriers that may affect your medical care?

Cultural / Religious Barrier	[]	[]
Language Barrier	[]	[]
Visual Barrier	[]	[]
Auditory Barrier	[]	[]