

**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:

	<b>No</b>	<b>Yes</b>		<b>No</b>	<b>Yes</b>
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:

	<b>No</b>	<b>Yes</b>	
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:

	<b>No</b>	<b>Yes</b>
Please Specify: _____	[ ]	[ ]
Latex	[ ]	[ ]
Shellfish	[ ]	[ ]
X-ray contrast	[ ]	[ ]

**Medications:**

Please list all medications that you currently take:

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

**Do you currently take:**

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

**Statistics:**    Height: \_\_\_\_\_    Weight: \_\_\_\_\_    Shoe Size: \_\_\_\_\_

**Social History:**

	<b>No</b>	<b>Yes</b>
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:	<b>No</b>	<b>Yes</b>
Coffee	[ ]	[ ] How much a day? _____
Soda with caffeine	[ ]	[ ] How much a day? _____
Tea	[ ]	[ ] How much a day? _____

**Family History:**

	<b>No</b>	<b>Yes</b>	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	[ ]	[ ]