

# Foot & Ankle Specialists, P.C. - Dr. Lawrence Mandel

Telephone 816-444-1100

Facsimile 816-444-1475

## Patient History

(The information that you provide will be kept strictly confidential)

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Please check any allergies that you know you have:

- |                                  |                               |                                     |
|----------------------------------|-------------------------------|-------------------------------------|
| <input type="radio"/> None Known | <input type="radio"/> Codeine | <input type="radio"/> Iodine        |
| <input type="radio"/> Penicillin | <input type="radio"/> Aspirin | <input type="radio"/> Tape          |
| <input type="radio"/> Sulfa      | <input type="radio"/> Latex   | <input type="radio"/> Others: _____ |

\_\_\_\_\_  
\_\_\_\_\_

Please check any medical conditions that you are aware you have or have had:

- |  |  |   |
|--|--|---|
| <input type="radio"/> None Known                               | <input type="radio"/> Diabetes                               | <input type="radio"/> Liver problems (other than<br>than hepatitis) |
| <input type="radio"/> HIV / AIDS                               | <input type="radio"/> Epilepsy                               | <input type="radio"/> Nerve problems                                |
| <input type="radio"/> Allergies (other than<br>to medications) | <input type="radio"/> Gastrointestinal (stomach)<br>problems | <input type="radio"/> Phlebitis                                     |
| <input type="radio"/> Anemia                                   | <input type="radio"/> Gastric reflux                         | <input type="radio"/> Respiratory problems                          |
| <input type="radio"/> Arthritis                                | <input type="radio"/> Glaucoma                               | <input type="radio"/> Rheumatic Fever                               |
| <input type="radio"/> Asthma                                   | <input type="radio"/> Gout                                   | <input type="radio"/> Seizures                                      |
| <input type="radio"/> Back Pain                                | <input type="radio"/> Heart Attack                           | <input type="radio"/> Sexually Transmitted Diseases                 |
| <input type="radio"/> Bleeding tendencies                      | <input type="radio"/> High Blood Pressure                    | <input type="radio"/> Stomach Ulcer                                 |
| <input type="radio"/> Breathing problems                       | <input type="radio"/> High Cholesterol                       | <input type="radio"/> Stroke  |
| <input type="radio"/> Cancer                                   | <input type="radio"/> Headaches                              | <input type="radio"/> Tuberculosis                                  |
| <input type="radio"/> Chest Pain                               | <input type="radio"/> Hepatitis (liver problems)             | <input type="radio"/> Thyroid problems                              |
| <input type="radio"/> Circulatory problems                     | <input type="radio"/> Kidney problems                        | <input type="radio"/> Vascular Disease                              |
|  | <input type="radio"/> Low Blood Pressure                     | <input type="radio"/> Vein problems                                 |

Others: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications that you are currently taking:

- |                            |                       |       |
|----------------------------|-----------------------|-------|
| <input type="radio"/> None | <input type="radio"/> | _____ |
| <input type="radio"/>      | <input type="radio"/> | _____ |
| <input type="radio"/>      | <input type="radio"/> | _____ |
| <input type="radio"/>      | <input type="radio"/> | _____ |
| <input type="radio"/>      | <input type="radio"/> | _____ |

\*\*\*\* Please complete the other side of this page \*\*\*\*

# Patient History

(The information that you provide will be kept strictly confidential)

## Injuries (please list):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Sprains, Fractures (Broken bones) or Dislocations (please list):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Hospitalizations (please list):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Operations - Surgeries (please list):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Social History:

Do you smoke? Yes - No    How much each day? \_\_\_\_\_    How long have you been smoking?

Do you drink alcohol? Yes - No    How much each day? \_\_\_\_\_    Are you an alcoholic? Yes - No

Please check the medical problems that run in your family? (two or more family members with the condition):

- |                                  |   |
|----------------------------------|---|
| <input type="radio"/> None known | <input type="radio"/> Heart Disease       |
| <input type="radio"/> Arthritis  | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> Cancer     | <input type="radio"/> Sickle Cell Anemia  |
| <input type="radio"/> Diabetes   | <input type="radio"/> Stroke              |
| <input type="radio"/> Gout       | <input type="radio"/> Others:             |

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