Dr. Edward Lang
Surgery of the Foot and Ankle

WELCOME

PATIENT INFORMATION

Date_____

Patient Name_____

Last

_____

First Middle Initial

Address_____

City_____

State_____Zip_____

E-mail_____

Sex ☐ M ☐ F Age_____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School_____

Employer/School Address_____

_____

Employer/School Phone (_____)_____

Spouse's Name_____

Birthdate_____

Whom may we thank for referring you?_____

PHONE NUMBERS

Home Phone (_____)_____

Cell Phone (_____)_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Home Phone (_____)_____

Work Phone (_____)_____

PRIVACY INFORMATION

Any contact information listed on this form, including phone numbers and email, will be used by this office to contact you about future appointments, billing, and routine correspondence.

Consent for Others to Access Your Account & Records

I give my consent for _____ (i.e. spouse, partner, adult child, etc.) to discuss and/or obtain my NOPA-related medical and account information in person, by phone, or by mail. I understand I may revoke given consent either in writing or in person at any time. Patient/Guardian signature: _____ Date: _____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you been to a podiatrist before?
☐ Yes ☐ No

If yes, please list

Name_____

Last Visit_____

Is there any personal or family history of diabetes?
☐ Yes ☐ No

Your occupation_____

Cigarette/Tobacco use_____

Years you smoked_____

Athletic activities in which you participate (list and indicate frequency)

_____

_____

_____

Please indicate which problems you now have or have had in the past.

Ankle Pain	☐Yes	☐No
Athlete's Foot	☐Yes	☐No
Bunions	☐Yes	☐No
Corns and Calluses	☐Yes	☐No
Cramps in Feet or Legs	☐Yes	☐No
Flat Feet	☐Yes	☐No
Heel Pain	☐Yes	☐No
Ingrown Toenails	☐Yes	☐No
Numbness in Feet or Legs	☐Yes	☐No
Plantar Warts	☐Yes	☐No
Swelling in Ankles or Feet	☐Yes	☐No
Tired Feet	☐Yes	☐No

MEDICAL HISTORY

Please indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Ear Problems	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Allergies to Anesthetics	☐Yes ☐No	Epilepsy	☐Yes ☐No	Rash	☐Yes ☐No
Allergies to Medicine or Drugs	☐Yes ☐No	Eye Problems	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Angina	☐Yes ☐No	Gout	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Arthritis	☐Yes ☐No	Headaches	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Artificial Heart Valves or Joints	☐Yes ☐No	Heart Disease	☐Yes ☐No	Special Diet	☐Yes ☐No
Asthma	☐Yes ☐No	Hemophilia	☐Yes ☐No	Stroke	☐Yes ☐No
Back Problems	☐Yes ☐No	Hepatitis/Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cancer	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Ulcers	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Liver Disease	☐Yes ☐No	Varicose Veins	☐Yes ☐No
Chest Pain	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Chronic Diarrhea	☐Yes ☐No	Neuropathy	☐Yes ☐No	Weight Loss, unexplained	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Phlebitis	☐Yes ☐No		
Diabetes	☐Yes ☐No	Psychiatric Care	☐Yes ☐No		

Surgeries You Have Had_____

_____

_____

Hospitalizations Other Than for the Surgeries Listed_____

_____

_____

Family Physician_____ Last Visit Date_____

Are you now or have you ever been under any other doctor's care for any reason over the past two years? ☐Yes ☐No

If yes, please explain._____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications, and vitamins:_____

_____

_____

Pharmacy Name(s)_____

Pharmacy Phone(s) (_____)_____

Do you take oral contraceptives? ☐Yes ☐No

ALLERGIES

☐ Adhesive Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafood
☐ Sulfa

Other_____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me or my minor child as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative — Date

_____ _____

Printed name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient