

Race: Required by Medicare (please check/circle one)

American Indian or Alaskan Native	Black or African American	White
Asian	Native Hawaiian or other Pacific Islander	Other:

Preferred Language: Required by Medicare

English/ Spanish/Other: _____

Ethnicity: Required by Medicare

Cuban/Hispanic or Latino/Mexican/Puerto Rican

Not Hispanic or Latino

Medical History:

Aids/ HIV	Y	N	Glaucoma	Y	N
Angina	Y	N	Heart attack/disease	Y	N
Anxiety	Y	N	High blood pressure	Y	N
Arthritis	Y	N	High cholesterol	Y	N
Asthma	Y	N	Hypothyroidism	Y	N
Back pain/problems	Y	N	Kidney disease	Y	N
Bleeding disorder	Y	N	Multiple sclerosis	Y	N
Blood Clots	Y	N	Osteoporosis	Y	N
Cancer (Type)	Y	N	Parkinson's disease	Y	N
Circulatory Problems	Y	N	Rheumatoid arthritis	Y	N
Dementia	Y	N	Rheumatic fever	Y	N
Diabetes	Y	N	Stroke	Y	N
Fainting/dizziness	Y	N	Swelling of the ankles/feet	Y	N
GERD (Gastric reflux)	Y	N	Varicose Veins	Y	N

Medications: Please list all medications you are currently taking including OTC/Vitamins

_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Medications: **No Known Allergies**

Acetaminophen	Y	N	Latex	Y	N
Adhesive Tape	Y	N	Lidocaine	Y	N
Aspirin	Y	N	Metal on skin	Y	N
Codeine	Y	N	Penicillin	Y	N
Erythromycin	Y	N	Soap	Y	N
Iodine	Y	N	Sulfa Drugs	Y	N
Keflex	Y	N	X-Ray dyes	Y	N

Family History: M = Mother F = Father

Arthritis	M	F	Heart Disease/Problems	M	F
Cancer (Type)	M	F	Melanoma	M	F
Diabetes Type I or Type II	M	F	Rheumatoid Arthritis	M	F
Foot Problems (Type)	M	F	Varicose Veins	M	F

Immunizations:

Date of Last Tetanus Shot: _____ Unknown

Surgical History:

Appendix	Y	N	Problems with anesthesia	Y	N
Gallbladder	Y	N	Heart Bypass	Y	N
Tonsils/Adenoids	Y	N	Hysterectomy	Y	N
Total Knee Replacement	Y	N	Foot/Ankle Surgery	Y	N
Total Hip Replacement	Y	N	Other:	Y	N

Social History:

Smoker Yes No Quit Packs/day _____

If yes, how long: _____ If Quit, how long ago: _____

Alcohol consumption: _____ / day week month **None**

Daily Activities: Active Inactive

Review of Systems:**Constitutional:**

Dizziness/fainting	Y	N
Headaches	Y	N
Unexplained chills/fever	Y	N
Vomiting/nausea	Y	N

Cardiovascular:

Angina (chest pain)	Y	N
Congestive heart failure	Y	N
Heart murmurs	Y	N
Palpitations	Y	N

Endocrine:

Excessive thirst/hunger	Y	N
Fatigue	Y	N
Hypoglycemia	Y	N
Unexplained weight loss	Y	N

Eyes, Ears, Mouth, Nose & Throat:

Blurred/loss of vision	Y	N
Diminished hearing	Y	N
Sinus/nasal congestion	Y	N
Tinnitus	Y	N

GI/GU:

Blood in stool	Y	N
Chronic diarrhea/constipation	Y	N
Painful urination	Y	N
Frequent urination	Y	N

Immunologic:

Animal allergies	Y	N
Gout	Y	N
Rheumatic disease	Y	N
Seasonal allergies	Y	N

Integumentary:

Cellulitis (skin infection)	Y	N
Eczema/psoriasis	Y	N
Sores/ulcer/wound	Y	N
Warts (hands/feet)	Y	N

Lymphatic:

Anemia	Y	N
Bloating	Y	N
Bruise easily	Y	N
Inability to stop bleeding	Y	N

Musculoskeletal:

Back/neck pain	Y	N
Foot/ankle pain	Y	N
Joint pain	Y	N
Muscle pain/stiffness	Y	N

Neurological:

Alzheimer's/dementia	Y	N
Head injury	Y	N
Seizure/epilepsy	Y	N
Stroke	Y	N

Psychological:

Anxiety	Y	N
Depression/emotional concern	Y	N
Panic attacks	Y	N
Poor sleep habits	Y	N

Respiratory:

Asthma	Y	N
Breathing problems	Y	N
Shortness of breath	Y	N
Sleep apnea	Y	N

Have you had an angioplasty or stent placed in the leg or heart?	Yes	No
Have you ever been told you have diabetes? Even borderline diabetes?	Yes	No
Do your legs ever feel tired causing you to stop and rest?	Yes	No
When you walk do you ever have to stop because you have pain or cramping in your calves or thighs?	Yes	No
Do you ever experience cramping, tightness, "Charlie horses" or pain in the legs or feet when lying down that improves when you stand up?	Yes	No
Do you have any infections or sores that are not healing on your feet or toes?	Yes	No
Is the skin on your legs or feet cool to the touch?	Yes	No
Is the skin on your legs or feet pale, reddish or purple?	Yes	No
Has anyone ever told you that you have poor circulation in your legs, intermittent claudication or peripheral arterial disease?	Yes	No
Have you ever had any testing done to your legs for these diseases?	Yes	No

Authorization to Discuss Confidential Medical Information

This form is **optional**. Please only complete this section if you would like to authorize Dr. Gretchen Heutsche/Dr. Angela Ostroski to discuss your confidential medical information with anyone other than yourself.

I, _____ give full authorization to discuss my medical treatment, medications, diagnosis, and/or financial information with the following parties only. I understand that my medical care will not be discussed with anyone that is not on this list.

Name

Relation

Name

Relation

Name

Relation

Name

Relation

I certify that all the above information is correct to the best of my knowledge

Name

Date