# MEDICAL INFORMATION

**DR. ELIZABETH PACOCHA**
**PHYSICIAN OF THE FOOT & ANKLE**

**Reason for your visit today** _____

**How long has this been bothering you?** ☐ Days ☐ Weeks ☐ Months ☐ Years

**Have you had any past problems with your feet and/or ankles?** ☐ **No** ☐ **Yes** If yes, please explain

_____

**Shoe Size** _____ **Weight** _____ **Height** _____

**Are you allergic to any medications?** ☐ **No** ☐ **Yes** If yes, please answer the questions below

Allergy to: ☐ Codeine ☐ Sulfa ☐ Penicillin

Other medications _____

**Other allergies** (i.e., tape, adhesive, shell fish, iodine, latex, etc.) _____

**Have you had any problems with local anesthetics?** ☐ **No** ☐ **Yes** If yes, please explain:

_____

## GENERAL HEALTH INFORMATION

**Do you have Diabetes?** ☐ **No** ☐ **Yes** If yes, do you take insulin? What kind? _____

**Do you have a history of Heart Problems?** ☐ **No** ☐ **Yes** If yes, please explain _____

**Do you have a history of serious illness?** ☐ **No** ☐ **Yes** If yes, please explain _____

**Please list any past surgeries you have had** _____

**Your Doctor's name** _____ **Phone #** _____

**Address** _____ **City** _____ **State** _____ **Zip Code** _____

**Date you last saw your Doctor?** _____

**Please list all prescription and over-the-counter medications you currently take:** _____

_____

_____

**Please check any of the following that have or have had a problem with:**

- ☐ Ankle/Feet Swelling
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Cancer
- ☐ Circulation Problems
- ☐ Dialysis
- ☐ Drug/Alcohol Abuse
- ☐ Frequent Infections
- ☐ Gout
- ☐ Headaches
- ☐ Hepatitis B Positive
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lung Disorder
- ☐ Mitral Valve Prolapse
- ☐ Numbness in Feet
- ☐ Neurological Problems
- ☐ Psychiatric Problems
- ☐ Rheumatic Fever
- ☐ Seizures/Epilepsy
- ☐ Sickle Cell
- ☐ Skin Problems
- ☐ Slow Healing
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis

**Do you have family history (blood relatives) of any of the following:**

- ☐ Arthritis
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Bunions
- ☐ Cancer
- ☐ Circulation Problems in Feet or Legs
- ☐ Diabetes
- ☐ Flat Feet
- ☐ Gout
- ☐ Hammertoes
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Neurological Problems
- ☐ Stroke

**Do you smoke?** ☐ **No** ☐ **Yes** If yes, number of packs per day _____

**Have you smoked previously?** ☐ **No** ☐ **Yes** If yes, for how long? _____

**Do you drink alcohol?** ☐ **No** ☐ **Yes** If yes, how much? ☐ 1-2 drinks per week ☐ 1-2 drinks per day ☐ more than 2 drinks per day

**Employment** ☐ Sits at Job ☐ Stands at Job ☐ Stands & Walks at Job ☐ Retired