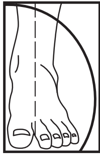

**Advanced Foot & Ankle Surgeons**
Surgical/Medical Management of Foot & Ankle Conditions

Mark E. Solomon, DPM
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1 Anderson Rd. Suite 102, Bernardsville, NJ 07924
**Phone (973) 285-1700 www.ADVfoot.com**


☐ Initial History ☐ Update of History Taken History As Of ______ ☐ Only changes to the previous history information are noted

## 1. Patient Identification & Contact Information

**Date:**

| First Name | MI | Last Name | Job/Occupation | ☐ I prefer to be addressed as: Mr. Mrs. Miss Ms. Dr. |
|---|---|---|---|---|

| E-mail Address: | Sex: M/F | Age: | Birth Date: | Shoe Size: | Weight: | Height: | ☐ I prefer to be addressed by: ○ First Name ○ Nick Name: |
|---|---|---|---|---|---|---|---|

Phone Numbers For Contacting You:
Day: ______
Evening: ______
Cell/Pager: ______

In Case of Emergency, Please Call: ______
Day: ______
Evening: ______

Preferred Pharmacy: ______
Street/City ______
Phone#: ______

## 2. Comprehensive Patient Medical History

**Have you had/been treated for:**

☐ Corns/Calluses
☐ Leg or Foot Ulcers
☐ Broken foot bone(s)
☐ Hammer/Mallet toes
☐ Cramps in legs/feet
☐ Lower back pain
☐ Gait (Walking) problems
☐ Childhood foot problems
☐ Warts
☐ Fungal nails
☐ Neuroma
☐ Broken Ankle
☐ Bunions
☐ Arch pain
☐ Knee pain
☐ In-toeing
☐ Rash
☐ Athlete's Foot
☐ Ingrown Nails
☐ Foot numbness
☐ Ankle sprain
☐ Flat feet
☐ High arch feet
☐ Heel Pain
☐ Toe walking
☐ NONE of these

**Did you previously or do you now wear:**
Orthotics? Y N Still using them? Y N Do or did they help? Y N

**Are your first steps out of bed painful?** Y N **...then subsides?** Y N

**Do you get leg cramps ....during the Day?** Y N **...at Night?** Y N

**Percent of waking hours spent on your feet?** 20% 40% 60% 80% 100%

**List of sports/type of dance you are active in:**

______

**Does foot pain limit your desired activities?** Yes ☐ No ☐
**Do you have any difficulty in walking?** Yes ☐ No ☐
**Any pain in calves or buttocks when walking?** Yes ☐ No ☐
**Is the pain relieved by stopping & standing still?** Yes ☐ No ☐

**Do you have or have you ever been treated for:**

☐ Stoke
☐ Phlebitis
☐ Anemia
☐ Diabetes
☐ Gout
☐ Sciatica
☐ Arthritis
☐ Epilepsy
☐ Asthma
☐ Hepatitis
☐ Dark Urine
☐ Cancer
☐ Heart Attack
☐ Vascular Disease
☐ Poor Circulation
☐ Kidney Disease
☐ Osteoporosis
☐ Lyme's Disease
☐ Headaches
☐ Nerve Disorder
☐ Lung Disease
☐ Liver Disease
☐ Chronic Lt. Stool
☐ Stomach Ulcer
☐ High Blood Pressure
☐ A Heart Condition
☐ Eyes: Glaucoma/Manicular Deg.
☐ Keloid/Thick Scar
☐ Alzheimer's
☐ Rheumatic Fever
☐ Hearing/Ear Disorder
☐ Psychiatric Disorder
☐ Tuberculosis
☐ Thyroid Problem
☐ Unexplained Weight Loss
☐ NONE of these
☐ Other(s): ______

**Do you have vascular grafts?** (If yes, explain below) Yes ☐ No ☐
**Do you have joint implants?** (If yes, explain below) Yes ☐ No ☐
**Do you have replacement heart valves?** Yes ☐ No ☐
**Are you now under active chemotherapy?** Yes ☐ No ☐
**Have you had any other serious illness?** (List below) Yes ☐ No ☐
**Have you had any surgery?** (If yes, explain below) Yes ☐ No ☐
**Have you ever been hospitalized or been under medical care over 24 hours?** (If yes, explain below) Yes ☐ No ☐

| I Had Surgery For: | on date of: | w/ complications of: |
|---|---|---|
| | | |
| | | |
| | | |

**List relationship to you of family members who have had:**

Diabetes ______
Arthritis ______
Stroke ______
Cancer ______
Foot Problems ______
Heart Attack ______
High Blood Pressure ______
Birth Defects ______

**# of childbirths ____ Are you currently pregnant?** ☐ Yes ☐ No
**Are you slow to heal after cuts?** ☐ Yes ☐ No
**Any abnormal bruising, bleeding or scarring?** ☐ Yes ☐ No
**Do you smoke now?** No ☐ Yes ☐ Packs/day ___ Years ______
**Did you ever smoke?** No ☐ Yes ☐ Packs/day ___ Years ______
**If you quit, when did you do so?**
**Alcoholic beverages? (circle one)** None Rarely Moderately Rarely Quit
**Recreational Drugs? (circle one)** None Rarely Moderately Rarely Quit
**Please mark if you take vitamins or supplements that contain**
Garlic ☐ Gingko biloba ☐ Echicacea ☐ Ginseng ☐ or St. John's Wort ☐
**Are you currently taking any medications?** List Below! ☐ Yes ☐ No
**Are you taking Insulin?** If yes, list below. ☐ Yes ☐ No

**When noting frequency: A = As needed, x/ = times per D = day, W = week**

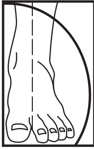
| List: Medications | Doses? | How Often? | For Treatment of? |
|---|---|---|---|
| | | A ____x/ D W | |
| | | A ____x/ D W | |
| | | A ____x/ D W | |
| | | A ____x/ D W | |

**Are you taking your medications as prescribed?** ____ **Yes** ____ **No**

**Allergies: Is there a history of skin reactions or other outward reaction or sickness following an injection, oral or topical administration of:**

| (Check the answer box that applies) | No | Yes | If yes, what happens? |
|---|---|---|---|
| Penicillin | ☐ | ☐ | |
| Other antibiotics (list below) | ☐ | ☐ | |
| Empirin, Tylenol (if yes, circle) | ☐ | ☐ | |
| Aspirin, Advil, Aleve, or Motrin (circle) | ☐ | ☐ | |
| Celebrex (circle) | ☐ | ☐ | |
| Other pain remedies (list below) | ☐ | ☐ | |
| Morphine | ☐ | ☐ | |
| Codeine | ☐ | ☐ | |
| Demerol | ☐ | ☐ | |
| Other narcotics (list below) | ☐ | ☐ | |
| Novocaine | ☐ | ☐ | |
| Other anesthetics (list below) | ☐ | ☐ | |
| Sulfa drugs | ☐ | ☐ | |
| Adhesive tape | ☐ | ☐ | |
| Shrimp, Iodine, or Merthiolate | ☐ | ☐ | |
| Any other drugs or medications | ☐ | ☐ | |

Others: ______
Anything else that you want to tell the doctor? Yes ☐ No ☐
Illnesses/Explanations: ______



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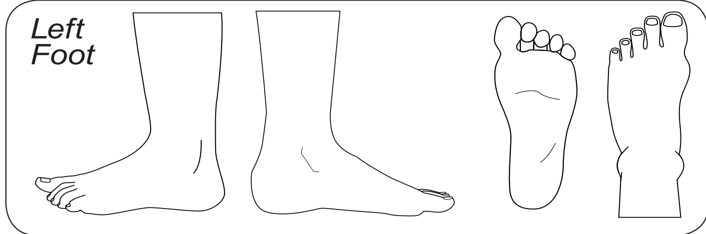
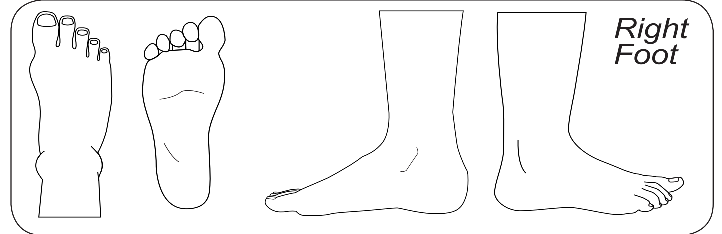
Patient Name | DOB / / | Date: / /

# 3. Patient Chief Complaints — CC/HPI

Descibe 1 or 2 main problems in greater detail below & mark on the diagrams below the areas where you have each problem using numbers 1 & 2 to identify them.




## 1.

Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and its cause if you know. Please describe associated pain to the right. My first problem is …
On Left foot ☐ On Right foot ☐ On Both feet ☐
It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it …

______________________________
______________________________
______________________________
______________________________
______________________________ is problem work related? Y N

Date of injury: / / Date of report to employer: / /

**Pain Level:** 0 **None** 1 **Light** 2 **Moderate** 3 **Strong** 4 **Severe**

**My Pain/Discomfort is:**

- ☐ Shooting Pain
- ☐ Throbbing Pain
- ☐ Sharp Pain
- ☐ Burning Pain
- ☐ Itching
- ☐ Aching Pain
- ☐ Tenderness
- ☐ Dull Pain
- ☐ Tingling
- ☐ Numbness

**How long ago did the problem (pain) start?** ____________
days ☐ weeks ☐ months ☐ years ago ☐

**My pain from my problem occurs:**
☐ While walking and/or ☐ While not walking
and/or: ____________
Previous medical treatment(s) or home remedies:
______________________________
______________________________
______________________________
______________________________

## 2.

Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and its cause if you know. Please describe associated pain to the right. My first problem is …
On Left foot ☐ On Right foot ☐ On Both feet ☐
It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it …

______________________________
______________________________
______________________________
______________________________
______________________________ is problem work related? Y N

Date of injury: / / Date of report to employer: / /

**Pain Level:** 0 **None** 1 **Light** 2 **Moderate** 3 **Strong** 4 **Severe**

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- ☐ Numbness

**How long ago did the problem (pain) start?** ____________
days ☐ weeks ☐ months ☐ years ago ☐

**My pain from my problem occurs:**
☐ While walking and/or ☐ While not walking
and/or: ____________
Previous medical treatment(s) or home remedies:
______________________________
______________________________
______________________________
______________________________

# 4. Patient's Doctors - Please tell us whom to thank and with whom to coordinate your care

| My: | Physician's Name: | Phone Number | City | Date Last Seen | Referred Me: | | I was sent or came especially for: | | |
|---|---|---|---|---|---|---|---|---|---|
| Family /Primary: | | | | | Y | N | 2nd Opinion | Surgcl Eval | Consult |
| Cardiologist: | | | | | Y | N | 2nd Opinion | Surgcl Eval | Consult |
| Orthopaedic: | | | | | Y | N | 2nd Opinion | Surgcl Eval | Consult |
| Endocrinologist: | | | | | Y | N | 2nd Opinion | Surgcl Eval | Consult |
| OB/GYN | | | | | Y | N | 2nd Opinion | Surgcl Eval | Consult |
| Neurologist: | | | | | Y | N | 2nd Opinion | Surgcl Eval | Consult |
| Other Specialist: | | | | | Y | N | 2nd Opinion | Surgcl Eval | Consult |

# 5. For Doctor's Use - Observations & Comments

☐ Patient was ○ assisted in completion of this record by or was ○ unable to complete without the help of: ____________
☐ Translation was done by ____________ in ○ Spanish ○ ____________
☐ Additional Information+ obtained from ○ Family/care givers and/or ○ Physician(s) ____________
☐ Lab Reports+ and/or ☐ Previous Medical Reports+ were reviewed ☐ X-rays+ brought by patient from ____________ were reviewed.
+Elaborations: ____________

______________________________

I have reviewed the information provided above ____________ My annotations to patient's entries are marked in ________ (ink color)
Doctor's Signature ____________ Date ____________ See Additional Documentation

☐ Only changes to the previous History Information are noted