Dr. Neal Blitz
Reconstructive Foot And Ankle Surgery

Todays Date:

PATIENT INFORMATION

Last Name:	First Name:	MI:
Date of Birth:	Age:	Sex: ☐ Female ☐ Male
Street Address:		APT #:
City:	State:	Zip:
Home #:	Cell #:	Work #:
Email Address:		Social Security #:
Occupation:		Employer:

REFERRAL INFORMATION

Name of Primary Care Provider:	
Address of Primary Care Provider:	
Phone of Primary Care Provider:	Fax of Primary Care Provider:

Who Referred you to us? *Circle one*

☐ Friend	☐ Close to job	☐ Physician:
☐ Family	☐Close to home	☐ Internet:
☐ Insurance Plan	☐ Hospital	☐ Other:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance:	ID #
Secondary Insurance:	ID #

EMERGENCY CONTACT INFORMATION

Name:	Relationship to Patient:	Phone:

PHARMACY INFORMATION

Name of Pharmacy:	Phone of Pharmacy:
Location of Pharmacy:	

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MEDICAL HISTORY
(check all that apply)

☐High Blood Pressure ☐ Heart Disease ☐ Heart Attack ☐ Heart Murmur ☐ HIV / AIDS ☐ Stomach Ulcers / Reflux	☐ High Cholesterol ☐ Thyriod Disease ☐ Liver Problems ☐ Hepatitis ☐ Diabetes ☐ Asthma	☐ Arthritis ☐ Rheumatoid Arthritis ☐ Bleeding Problems/Disorder ☐ Fibromyalgia ☐ Cancer: ☐ Neurologic Problems: ☐ Psychiatric Problems: ☐ Skin Problems:
☐ Other:		

PAST SURGICAL HISTORY
(check all that apply)

☐ Joint Replacement: ☐ Fracture Surgery: ☐ Surgery for Circulation:	☐ Gall Bladder ☐ Appendix ☐ C-section ☐ Heart Surgery ☐ Other:

MEDICATIONS
(include any over-the-counter medications)

Have you ever been put to sleep for surgery? ☐ No ☐Yes

Have you or any memember of your family had problems with anesthesia? ☐ No ☐Yes

ALLERGIES
(indicate the reaction)

☐ No Allergies	☐ Foods	☐ Anti-inflammatories	☐Shellfish
☐ Penicillin	☐ Tape	☐ Codeine	☐ Other:
☐ Sulfa	☐ Latex	☐ Iodine	

SOCIAL HISTORY

Marital Status:	**Living Arrangement:**	**Use of Tobacco:** ☐ No ☐Yes
☐ Single	Live alone: ☐ No ☐Yes	Quit? How long ago:
☐ Married	Elevator: ☐ No ☐Yes	Smoke? packs per day
☐ Partnered	Stairs: ☐ No ☐Yes	**Use of Alcohol:** ☐ No ☐Yes
☐ Divorced	Pets: ☐ No ☐Yes:	☐occasional ☐social ☐daily
☐ Widowed	Young Kids: ☐ No ☐Yes	**Drugs Use:** ☐ No ☐Yes

Do you Exercise? ☐ No ☐Yes, describe:

FAMILY HISTORY

☐Stroke	☐Heart Disease	☐Diabetes	☐Rheumatoid Arthritis
☐Cancer	☐High Blood Pressure	☐Thyroid Problems	☐Other:

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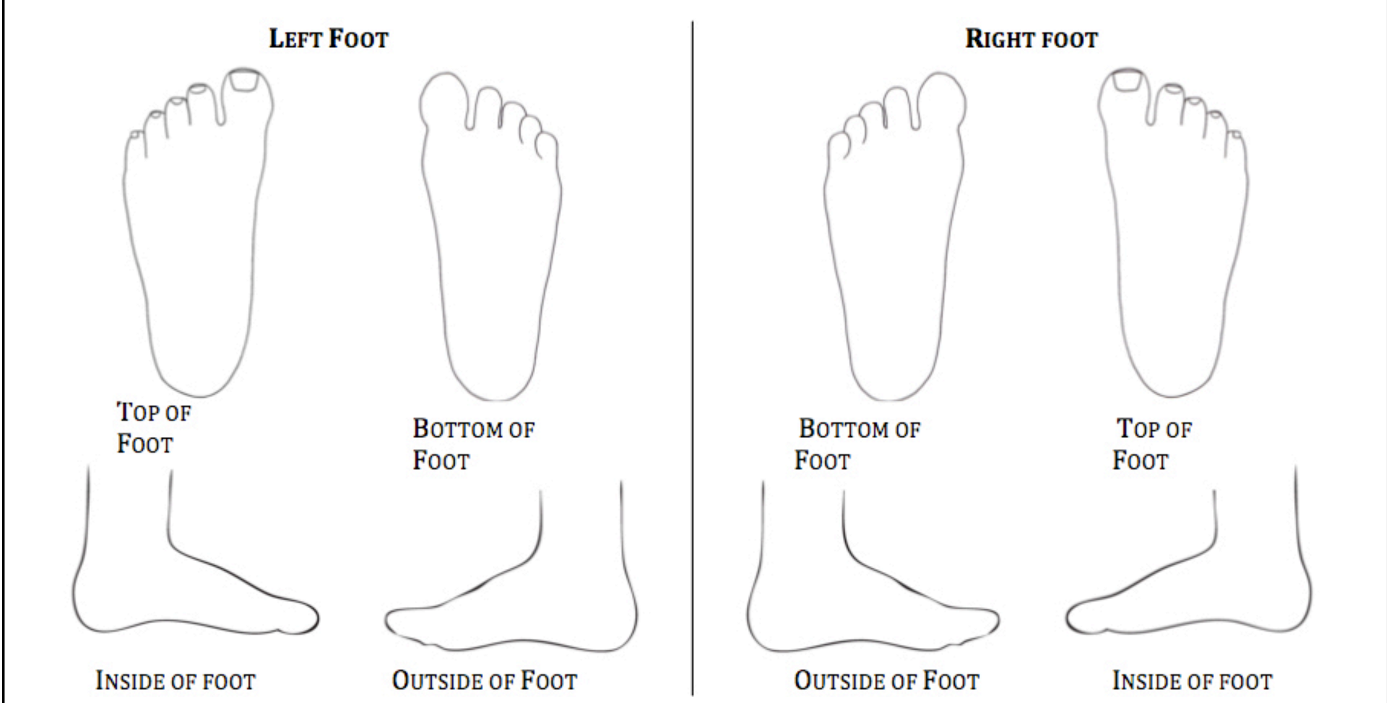
FOOT & ANKLE PROBLEM	
How tall are you?	**How much do you weigh?**
Where is the problem on your foot? Please mark the pictures below	



How long ago did this problem start? □Days: □Months: □Years:

How did the problem/pain start? □Suddenly □ Gradually over time

How would you rate the pain on a scale of 1 - 10?

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

How would you describe the pain/discomfort? (check all that apply)

□None □Sharp □Dull □Aching □Burning □ Other:
□Radiating □Itching □Stabbing □Throbbing □Tingling

What makes the pain better?

What makes the pain worse? □walking □ standing □ daily activities □other:

What treatments have you tried?

Was this probem cause by an injury? □ No □Yes: Work injury? □ No □Yes

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ADDITIONAL INFORMATION

Any additional information that you want to include for the doctor?

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

____
Print Name of Patient, Parent or Guardian

____
If Other than Patient, Relationship to Patient

____
Name of Doctor

____
Signature **Date**

____
Sigature of Doctor