INITIAL PATIENT FORM

Reason for your visit: ___________________________________________________  Visit Date: ______________

CIRCLE AREA(S) OF CONCERN:

Left

Right

TOP/BOTTOM

OUTSIDE

INSIDE

Type of pain:
□ Sharp
□ Burning
□ Soreness
□ Tightness

□ Stabbing
□ Numbness
□ Aching
□ Pressure

□ Shooting
□ Tingling
□ Throbbing

□ Pulling
□ Radiating
□ Cramping

□ Tearing
□ Electric shocks
□ Pins & needles

Pain Level (0-10): ________
Patient Name: ___________________________________________  DATE OF BIRTH: ____________________

PRIMARY CARE PHYSICIAN: __________________________________________________________

REFERING PHYSICIAN: ________________________________________________________________

LIST OF TREATING PHYSICIANS (other than Primary Care and Referring):

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
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PHARMACY  Name: _____________________________
          Street Address: _____________________________________________________________
          City: _____________________________ Phone: _____________________________

HOME HEALTH  Name: _____________________________
AGENCY:  Street Address: _____________________________________________________________
          City: _____________________________ Phone: _____________________________
CURRENT MEDICATIONS including over-the-counter & supplements:

<table>
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<tr>
<th>Name of Medication</th>
<th>Dose</th>
<th>How often taken</th>
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<tr>
<td>Example: Metformin</td>
<td>500 mg</td>
<td>1 tablet, 2 times daily</td>
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</table>

□ Provided attached list
VASCULAR & DIABETIC FOOT CENTER

Patient Name: ______________________________________ DATE OF BIRTH: _______________________

PAST MEDICAL HISTORY (e.g. diabetes mellitus, hypertension, hypercholesterolemia, etc.):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

PAST SURGICAL HISTORY (e.g. appendectomy, tonsillectomy, etc.) including date(s):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

DRUG ALLERGIES / REACTIONS (name & reaction):

□ No Known Drug Allergies

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

FAMILY (not personal) HISTORY: (Mother, Father, Sibling, etc.) □ Adopted – No known family history

□ Cancer ________________  □ Arterial Disease______________

□ Diabetes ________________  □ Kidney Disease ____________

□ Heart Disease ____________  □ Lung Disease ______________

□ Hypertension ____________  □ Mental Illness _____________

□ Adopted – No known family history
Patient Name: ___________________________________________ DATE OF BIRTH: _________________________

SOCIAL HISTORY:

Tobacco Use:

☐ Current every day smoker: Year started: ______ ☐ Cigarettes: ____ per day ☐ Cigars: ____ per day

☐ Former Smoker: Year quit: ______

☐ Never Smoker

☐ Smokeless Tobacco: Year started: ______ Type ___________________ Amount per day ______

☐ Nicotine gum or patch: Amount per day ______

☐ Electronic Cigarettes: Year started: ______ Amount per day ______

Caffeine Use: ☐ Yes ☐ No Type ___________________ Cups per day ______

Alcohol Use: ☐ Yes ☐ No Type ___________________ Amount per day ______

Substance Abuse: ☐ Yes ☐ No Substance (e.g. cocaine, marijuana) _________________________________

Illicit Drug Use: ☐ Yes ☐ No Drug (e.g. OxyContin, Hydrocodone) _________________________________

Marital Status: ______________ # Children: ____ Occupation: ___________________________________

Lives in (e.g. home, apartment): ______________ Lives with (e.g. no one, spouse): ______________

Cultural, Religious, or Language Concerns: ________________________________________________________________

ADVANCED DIRECTIVES AND INSTRUCTIONS:

Advanced Directives: ___________________________________________ ☐ Do not resuscitate

Durable power of attorney for healthcare: _________________________________________________________________

FALL RISK ASSESSMENT:

History of Falling: ☐ Yes ☐ No

Secondary Diagnosis (have more than 1 medical diagnosis): ☐ Yes ☐ No

Aids for walking: ☐ none/wheelchair/bed rest ☐ crutches/cane/walker ☐ furniture (use for support)

IV or IV Access: ☐ Yes ☐ No Gait: ☐ normal / wheelchair / bed rest ☐ weak ☐ impaired

Mental Status: ☐ oriented/understand own ability ☐ overestimate or forget limitations

Have you experienced or more falls without injury within past year: ☐ Yes ☐ No

Have you experienced any fall with injury within past year: ☐ Yes ☐ No
### Constitutional:
- □ None
- □ chills
- □ fatigue
- □ fever
- □ loss of appetite
- □ marked weight change
- □ night sweats
- □ weight gain
- □ unintentional weight loss
- □ weakness
- □ other: ______________________

### Eyes:
- □ None
- □ blurred vision
- □ discharge/drainage
- □ double vision/spots/flashlighting
- □ dry eyes
- □ excessive tearing
- □ eye pain
- □ glasses/contacts
- □ partial/complete blindness
- □ sensitivity to light
- □ vision changes
- □ other: ______________________

### Ears/Nose/Mouth/Throat:
- □ None
- □ bleeding gums
- □ current infection
- □ dental problems
- □ difficulty clearing ears
- □ bad breath
- □ hearing loss/aid
- □ hoarseness
- □ ear pain
- □ frequent colds
- □ loss of smell
- □ loss of taste
- □ nasal congestion
- □ nose bleeds
- □ earache
- □ painful/swollen lymph nodes
- □ post nasal drip
- □ sore throat
- □ other: ______________________

### Cardiovascular:
- □ None
- □ chest pain
- □ profuse sweating
- □ difficulty breathing on exertion
- □ edema
- □ leg pain when walking
- □ leg resting pain
- □ leg swelling
- □ difficulty breathing laying down
- □ palpitations
- □ fainting
- □ other: ______________________

### Gastrointestinal:
- □ None
- □ acid reflux
- □ bloody stools
- □ bowel incontinence
- □ change in bowel habits
- □ constipation
- □ diarrea
- □ difficulty swallowing
- □ hemorrhoids
- □ indigestion
- □ jaundice
- □ loss of appetite
- □ nausea/vomiting
- □ rectal bleeding
- □ stomach/abdominal pain
- □ vomiting of blood
- □ other: ______________________

### Genitourinary:
- □ None
- □ abnormal vaginal bleeding
- □ bladder spasm
- □ blood in urine
- □ decreased force in stream
- □ urinary incontinence
- □ voiding multiple times at night
- □ painful urination
- □ pregnant
- □ urinary incontinence
- □ other: ______________________

### Integumentary:
- □ None
- □ change in hair, skin, nails
- □ skin dryness
- □ calluses/corns
- □ change in mole appearance
- □ itching
- □ lesions
- □ lumps
- □ prone to skin tears
- □ rash
- □ skin allergies
- □ sun sensitivity
- □ other: ______________________

### Endocrine:
- □ None
- □ cold intolerance
- □ heat intolerance
- □ excessive thirst
- □ excessive hunger
- □ excessive urination
- □ other: ______________________

### Musculoskeletal:
- □ None
- □ assistive devices: ___________________
- □ backache
- □ contractures
- □ decreased activity
- □ deformities
- □ joint pain
- □ joint swelling
- □ muscle pain
- □ muscle wasting
- □ muscle weakness
- □ other: ______________________

### Neurologic:
- □ None
- □ abnormal gait
- □ dizziness
- □ headaches
- □ loss of sensation to feet
- □ memory loss
- □ numbness
- □ one-sided weakness
- □ paralysis
- □ seizures
- □ spasms
- □ tingling
- □ tremors
- □ weakness
- □ other: ______________________

### Hematologic/Lymphatic:
- □ None
- □ bruising easily
- □ bleeding/clotting disorders
- □ bleeding tendency
- □ blood transfusions
- □ enlarged lymph nodes
- □ swelling
- □ swollen glands
- □ other: ______________________

### Allergic/Immunologic:
- □ None
- □ frequent rashes
- □ hay fever
- □ hives
- □ runny nose
- □ recurrent fevers
- □ other: ______________________

### Psychiatric:
- □ None
- □ anxiety
- □ claustrophobia
- □ insomnia
- □ nervousness/tension
- □ restraints
- □ suicidal
- □ memory loss
- □ depression
- □ other: ______________________