Augusta Foot & Ankle
New Patient Information Form

Full Name:				Date of Birth:	
Address:		City:		State:	Zip:
Sex:	SSN:	Home Phone:		Marital Status: M/S/D/W	
Place of Employment:		Work Phone:		Alternate Phone:	
Spouse's Name:		Spouse DOB:		Spouse SSN:	
Parent's Name (if patient is a minor)		Parent's SSN:		Height:	Weight:
Insurance #1 Name:			Insurance #1 ID#:		
Insurance #2 Name:			Insurance #2 ID#:		

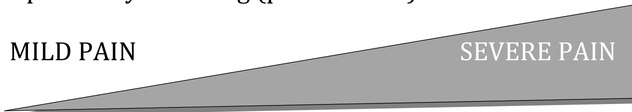
Problem History

In your own words, please describe the problem you are having:

____

____

How much pain are you having (please circle)?



NONE (0) 1 2 3 4 5 6 7 8 9 10

Who is your regular doctor? ______________________________

Who referred you to us? ______________________________

Social History

Do you smoke? YES/NO How much?______________________

Do you drink alcohol? YES/NO How much? ________________

Occupation: ______________________________

Medical History

Are you allergic to any medicines (please circle)?

Penicillin Sulfa Codeine Aspirin Adhesive Iodine

Other: ______________________________

Please list any (& all) allergies other than medication:

____

Please list all current medications (& dose) and supplements:

______________ ______________

______________ ______________

______________ ______________

Please list all previous surgeries and hospitalizations:

______________ ______________

______________ ______________

______________ ______________

Medical Review of Systems

Please check (√) if you or a family member have or have had any of the following:

Condition	Patient	Family
Diabetes		
High Blood Pressure/Hypertension		
Heart Attack/Heart Disease		
High Cholesterol		
Poor Circulation		
Stomach Ulcer/Frequent Heartburn		
Cancer		
Frequent Headaches		
Frequent Blurred or Double Vision		
Epilepsy		
Bleeding from the ears or nose		
Thyroid Problems		
Chest Pain/Angina		
Anemia/Low Blood		
Excessive Bleeding		
Difficulty Breathing/Wheezing/Asthma		
Tuberculosis		
Rheumatic Fever		
Pneumonia		
Colon Disease		
Gallbladder Disease		
Kidney Problems		
Liver Disease or Jaundice		
Hepatitis		
Bone or Joint Disease (Arthritis)		
Bursitis/Sciatica		
Phlebitis or Vein Problems		
Leg or Night Cramps		
Tested positive for HIV		

Please list any other medical problems: