Dr. L. Craig Semer
Foot & Ankle Surgeon
Podiatrist

**Medical and Podiatry Information**
**(Important to our files and your health)**

Patient Name _____

**Family Physician** _____

**Address** _____

**Phone #**

**Former Podiatrist** _____

**Chief Foot Complaint** _____

_____

_____

If this is an injury please complete:
Date of injury _____ Place of Injury _____
Were you treated previously, where and by whom?

_____

_____

Have you ever been treated for this foot complaint previously? If yes, please advise where and by whom?

_____

_____

If this is an injury, are you seeking legal damages? ( ) Yes ( ) No

Name of Attorney _____

Address of Attorney _____

How many of the following types of sports activity do you participate in?

| | | | | | |
|---|---|---|---|---|---|
| running | ( ) | football | ( ) | aerobic dancing | ( ) |
| tennis | ( ) | racquetball | ( ) | bicycling | ( ) |
| walking | ( ) | basketball | ( ) | swimming | ( ) |
| golf | ( ) | jogging | ( ) | | |

Do you experience any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| numbness | ( ) | swelling | ( ) | corns | ( ) | athletes feet | ( ) |
| burning | ( ) | itching | ( ) | callouses | ( ) | tired feet | ( ) |
| tingling | ( ) | cramps | ( ) | bunions | ( ) | ingrown toenails | ( ) |

Please describe in your own words _____

_____

_____

_____

_____

## PATIENT INFORMATION

Are you in general good health?___ yes, ___ no
Are you subject to profuse bleeding?___ yes, ___ no
Do you have low back pain?___ yes, ___ no

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## PRESENT OR PAST DISEASES

| | | | | |
|---|---|---|---|---|
| ___ Measles | ___ Arthritis | ___ Hepatitis | ___ Kidney Disease | ___ Cancer |
| ___ German M. | ___ Meningitis | ___ Scarlet Fever | ___ Diabetes | ___ Stroke |
| ___ Mumps | ___ Hypertension | ___ Rheumatic Fever | ___ Pneumonia | ___ Heart Attack |
| ___ Chicken Pox | ___ Anemia | ___ Syphilis | ___ Pleurisy | ___ Gout |
| ___ Small Pox | ___ Jaundice | ___ Gonorrhea | ___ Tuberculosis | ___ Sickle Cell Anemia |
| ___ Polio | ___ Malaria | ___ Epilepsy | ___ Bronchitis | ___ Other: _____ |
| ___ Tonsilitis | ___ Typhoid Fever | ___ Colds (Flu) | ___ Veneral Disease | _____ |

## HOSPITALIZATIONS: Illness, Surgery. List most recent first. Include foot surgery. Office or Hospital

Date: _____ Diagnosis: _____ Operation: _____
Dr. _____ Hospital: _____ Location: _____
Date: _____ Diagnosis: _____ Operation: _____
Dr. _____ Hospital: _____ Location: _____
Date: _____ Diagnosis: _____ Operation: _____
Dr. _____ Hospital: _____ Location: _____
Date: _____ Diagnosis: _____ Operation: _____
Dr. _____ Hospital: _____ Location: _____
Date: _____ Diagnosis: _____ Operation: _____
Dr. _____ Hospital: _____ Location: _____

## MEDICATIONS YOU PRESENTLY TAKE: (vitamins, aspirin, maalox, etc.)

Name _____ Strength _____ Doses per day: 1, 2, 3, 4
Name _____ Strength _____ Doses per day: 1, 2, 3, 4
Name _____ Strength _____ Doses per day: 1, 2, 3, 4
Name _____ Strength _____ Doses per day: 1, 2, 3, 4

## ARE YOU ALLERGIC OR SENSITIVE TO: (Redness of skin, itching, shortness of breath, fainting.)

| | | | | | |
|---|---|---|---|---|---|
| ___ Penicillin | ___ Anesthetics | ___ Foods | ___ Darvon | ___ Iodine | Others: _____ |
| ___ Novocaine | ___ Dogs | ___ Milk | ___ Codeine | ___ Pollens | _____ |
| ___ Xylocaine | ___ Cats | ___ Strawberries | ___ Steroids | ___ Alcohol | _____ |
| ___ Marcaine | ___ Band-aids | ___ Aspirin | ___ Cortisone | ___ Sulfas | _____ |

## SOCIAL HISTORY

Smoke: ___ Less than 1 pack per day; 1, 2, 3, packs/day. Duration: ___ mos. ___ yrs.
Drink: ___ social; ___ weekends; ___ daily; ___ liquor; ___ beer. Duration: ___ mos. ___ yrs.
Drugs: type _____. Addiction: ___ yes; ___ no. Duration: ___ mos. ___ ___ yrs.
Diet: ___ meals/day. regular ___ yes; ___ no. 1, 2, 3, 4, per day. Vegetarian ___ yes, ___ no.
Married: ___ Married ___ Single ___ Widowed ___ Divorced
Education: ___ High School ___ College ___ Graduate School. Area: _____
Hobbies: ___ reading ___ sports ___ other: _____

## FAMILY HISTORY

| | | | | |
|---|---|---|---|---|
| Mother _____ | ___ Tuberculosis | ___ Diabetes | ___ Malignancy | ___ Corns |
| Father _____ | ___ Heart Disease | ___ Kidney Disease | ___ Epilepsy | ___ Callouses |
| Sister _____ | ___ High Blood Pressure | ___ Arthritis | ___ Anemia | ___ Ulcers |
| Brother _____ | ___ Syphilis | ___ Gout | ___ Bunions | |
| Other _____ | | | | |

PLEASE SIGN

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

I hereby give my permission to administer treatment, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the foot/ankle/leg condition.

DATE: _____/_____/_____ SIGNATURE: _____

*"THANK YOU"*