Kierstein & DiFrancesca, DPM, PC

History and Intake Form

Last Name: _____ First Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (night): _____

Email Address: _____ Occupation / Workplace: _____

Emergency Contact (name): _____ Emergency Contact (number): _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Primary Care Provider: _____ ***Referring Physician:*** _____

Preferred Pharmacy

(Primary - *default*)

Name: _____

Phone Number: _____

City or Zip Code: _____

(Secondary – *if applicable*)

Name: _____

Phone Number: _____

City or Zip Code: _____

Past Medical Conditions

Select any of the following medical conditions you currently have:

- ☐ None
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung Disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Disease caused by 2019-nCoV
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ H/O: hypertension
- ☐ Hearing loss
- ☐ Human immunodeficiency virus infection
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of prostate
- ☐ Radiation therapy treatment management
- ☐ Transplantation of bone marrow
- ☐ Other

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History and Intake Form

Past Surgeries

Have you had any surgeries on the following organs?

- ☐ None
- ☐ Abdominoperineal resection
- ☐ Bilateral replacement of knee joints
- ☐ Biopsy of breast
- ☐ Biopsy of prostate
- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ H/O: colostomy
- ☐ H/O: tubal ligation
- ☐ History of appendectomy
- ☐ History of bilateral mastectomy
- ☐ History of cholecystectomy
- ☐ History of colectomy
- ☐ History of liver excision
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissue heart graft valve replacement
- ☐ History of total cystectomy
- ☐ History of transurethral prostatectomy
- ☐ Hysterectomy
- ☐ Kidney biopsy
- ☐ Low anterior resection of rectum
- ☐ Lumpectomy of breast
- ☐ Lumpectomy of left breast
- ☐ Lumpectomy of right breast
- ☐ Mastectomy of left breast
- ☐ Mastectomy of right breast
- ☐ Mechanical heart valve replacement
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Percutaneous extraction of kidney stone with fragmentation procedure
- ☐ Portosystemic shunt operation
- ☐ Prostatectomy
- ☐ Prosthetic arthroplasty of bilateral hips
- ☐ Splenectomy
- ☐ Surgical biopsy of the skin
- ☐ Total nephrectomy
- ☐ Total orchidectomy
- ☐ Total replacement of left hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of right knee joint
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ Other

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Podiatric Foot/Ankle Disease History

Have you had any of the following?

- ☐ NONE
- ☐ Acquired cavus deformity of foot
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome

History and Intake Form

- [ ] Acquired pes planus
- [ ] Amputation
- [ ] Ankle ulcer
- [ ] Bone tumor
- [ ] Chronic pain
- [ ] Deep venous thrombosis
- [ ] Dystrophia unguium
- [ ] Foreign body
- [ ] Fracture of bone
- [ ] Gangrenous disorder
- [ ] Hallux valgus
- [ ] Laceration - injury
- [ ] Localized infection
- [ ] Neoplasm of soft tissue
- [ ] Neuroma of foot
- [ ] Osteoarthritis
- [ ] Peripheral nerve disease
- [ ] Peripheral vascular disease
- [ ] Peripheral venous insufficiency
- [ ] Plantar fasciitis
- [ ] Primary gout
- [ ] Recurrent falls
- [ ] Rheumatoid Arthritis
- [ ] Rupture of Achilles tendon
- [ ] Sprain of lateral ligament of ankle joint
- [ ] Ulcer of foot
- [ ] Other

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Podiatric Foot/Ankle Surgical History

Have you had any of the following?

- [ ] NONE
- [ ] Amputation
- [ ] Amputation of left foot
- [ ] Amputation of left leg through tibia and fibula
- [ ] Amputation of left lower limb above knee
- [ ] Amputation of right foot
- [ ] Amputation of right leg through tibia and fibula
- [ ] Amputation of right lower limb above knee
- [ ] Arthrodesis of ankle
- [ ] Arthrodesis of foot
- [ ] Arthroscopy of ankle
- [ ] Cryotherapy of warts
- [ ] Decompression of tarsal tunnel
- [ ] Excision of accessory navicular bone
- [ ] Excision of peripheral neuroma
- [ ] Excision of subcutaneous tumor of extremities
- [ ] Fasciotomy of foot
- [ ] Foot repair
- [ ] Hammer toe repair
- [ ] Incision AND drainage
- [ ] Lengthening of tendon
- [ ] Metatarsal osteotomy for correction of congenital deformity of foot
- [ ] Nail plate procedure
- [ ] Open reduction of fracture
- [ ] Open reduction of fracture of sesamoid
- [ ] Removal of foreign body
- [ ] Repair of hallux valgus
- [ ] Repair of tendon
- [ ] Tarsometatarsal arthrodesis, transverse with osteotomy as for flatfoot correction
- [ ] Other

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Podiatric Foot/Ankle Family History

Is there a history of any of the following? (*Immediate family)

- [ ] NONE
- [ ] Charcot Marie Tooth Disease
- [ ] Congenital deformity foot
- [ ] Acquired ples planus
- [ ] Acquired cavus deformity of foot
- [ ] MSK Osteoporosis

- [ ] Other _____

Podiatric Foot/Ankle Pediatric History

Is there a history of any of the following?

- [ ] NONE
- [ ] Scoliosis deformity spine
- [ ] Breech delivery
- [ ] Hip dysplasia
- [ ] Talipes equinovarus
- [ ] Calcaneovalgus deformity foot
- [ ] Congenital vertical talus
- [ ] Metatarsus adductus
- [ ] Metatarsus primus varus
- [ ] Tarsal coalitions

- [ ] Other _____

Medications

Please list ALL current medications *(or check the box if it applies)*

- [ ] *Currently not taking any medication(s)*

Medication	Dosage	Frequency

History and Intake Form

Allergies

Please list ALL known allergies *(or check the box if it applies)*

☐ *No Known Allergies (NKA)*

Using the following options, describe your reaction(s) with severity provided below

Reaction Types			Severity Scale
Anaphylaxis	Angioedema	Diarrhea	Mild
Dizziness	Fatigue	GI upset	Mild to Moderate
Hives	Liver toxicity	Nausea	Moderate
Rash	Shortness of breath	Swelling	Moderate to Severe
Weal	Other: (specify)		Severe
			Fatal

	Allergy	Reaction(s)	Severity
1.)			
2.)			
3.)			
4.)			
5.)			

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Exercise Frequency (please choose one):

- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

History and Intake Form

Family History

Please include only first-degree relatives:

_____ _____

_____ _____

_____ _____

Review of Systems

Symptom	Yes	Symptom	Yes	Symptom	Yes
Joint Pain		Poor healing wounds		Ringing in ears	
Joint swelling		Redness		Hoarseness	
Joint stiffness		Rash		Heartburn	
Unsteady gait		Itching		Nausea/vomiting	
Numbness		Scarring/ keloids		Constipation	
Tingling		Easy bleeding		Diarrhea	
Headaches		Easy bruising		Shortness of breath	
Dizziness		Enlarged nymph nodes		Wheezing	
Tremors		Chest pain		Cough	
Fatigue		Palpitations		Hurts to breathe	
Unexpected weight loss		Fainting		Nervousness	
Fever		Heart murmur		Anxiety	
Chills		Leg cramps		Depression	
Weight gain		Nose bleeds		Hallucinations	

Alerts

Please check yes for the following if it applies:

Alert	Yes
Pacemaker	
Blood thinners	
Defibrillator	
Premedication prior to procedures	
Rheumatoid Arthritis	
RSD	
Allergy to shellfish/iodine	
Allergy to latex	
Allergy to adhesive	
Under pain management	