

DeLand Foot and Leg Center, LLC

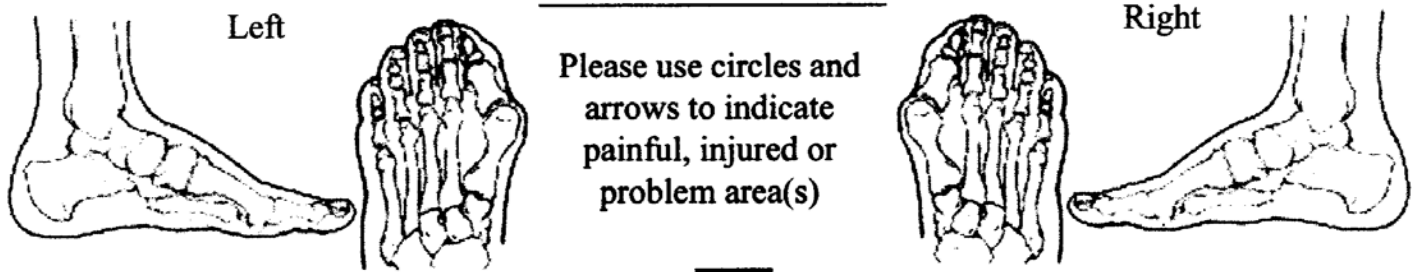
PATIENT QUESTIONNAIRE INITIAL EVALUATION

Date: _____

Patient Name: _____ (Office use only) MR# _____

Family/Primary Doctor: _____ Who referred you to DeLand Foot and Leg Center? _____

INSTRUCTIONS: Please complete the following questions before you see the doctor. **Circle the word or phrase that best describes your situation. You may select more than one answer per question.** Answer the question in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. **THANK YOU.**



REASON FOR VISIT: _____

HOW LONG HAS IS PROBLEM BEEN PRESENT? _____

IS THE PROBLEM: Improving Getting Worse Not changing

THE PAIN SCALE IS: 0 1 2 3 4 5 6 7 8 9 10 (worst)

ARE YOU TAKING ANY MEDICATION FOR THIS PROBLEM? _____

DOES THE MEDICATION HELP? Yes No

WHAT AGGREGATES THE PROBLEM? _____

WHEN IS THE PROBLEM WORSE? Morning End of day While sleeping

MEDICAL HISTORY: No known medical problems

- | | | |
|--|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> CAD | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Adult Diabetes | <input type="checkbox"/> Childhood Diabetes | <input type="checkbox"/> Past heart attack |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hepatitis A/ B / C |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Seizure disorders | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> COPD/Lung dz | <input type="checkbox"/> Immune Disorder | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> DVT | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other: _____ |

PAST SURGICAL HISTORY: No previous surgeries

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Lumbar laminectomy |
| <input type="checkbox"/> Cataract extraction | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> By-pass / open heart |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Other: _____ | |

HOW MUCH ALCOHOL DO YOU CONSUME?

- A) I'm a non-drinker
- (B) I'm a recovering alcoholic
- (C) I drink only occasionally
- (D) I drink weekends only
- (E) An average of 1-2 drinks per day
- (F) An average of 3 or more

TOBACCO USAGE:

- (A) Yes, I am currently a smoker or use tobacco
I smoke (circle one) 1 2 3 packs/day
I have smoked for _____ years
- (B) No, but I did for _____ years
- (C) No, I have never used tobacco

MEDICATIONS: None

NAME	DOSE

ALLERGIES: No Known Drug Allergies Name of Drugs: _____

THE FOLLOWING CHECK MARKS INDICATE ABNORMALITIES.

- I HAVE NO PROBLEMS**
- blurred vision headaches stiffness difficulty swallowing
- chest pain palpitations SOB coughing
- nausea vomiting frequent urination
- leg cramping resting pain in toes swelling
- arthritis joint pain total joint implant

Everything I have answered is true, complete, and correct to the best of my knowledge. Failure to provide a truthful medical history may result in serious complications or harm.

Patient or Guardian's Signature / Date

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.
IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD
AT DELAND FOOT AND LEG CENTER, LLC.