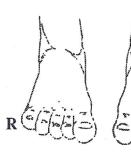
The Foot & Ankle Clinic, LLC. Patient Registration, Part 2

				,	DATE			
NAME		B.P	HEIGH	Τ	_ SHOE SIZE	EWEIG	HT	
Do You Have a history of the following			Have You Ever Had ALLERGIES to any of the following			Please list al medications supplements, vitamins, and over the counter products you are currently taking		
Diabetes Insulin Heart Problems Mitral Valve Prolapse Blood Clots Stroke Seizures High Blood Pressure Arthritis/Gout Asthma Bleeding Tendency Infection Recurrent Infection HIV/AIDS Cancer Poor Circulation	Yes No Yes No	Oth Asp NS, Loo Nov Coo IVP Adh Oth	nicillin er Antibiotics birin AIDS al Anesthetics vocaine deine Dye nesive Tape er					
Reason for today's visit Circle symptoms you ar	use recreationa oyed? Yes lized in the past re had and dates y of the following od Pressure re experiencing:	I drugs? Yes No If y year? If yes g: Stroke Pain Sv	es, list number, Why? Cancer Founting Burn	of hours stan	High Chol	esterol He	eart disease Stabbing	
On a Scale of 1 to 10 (What causes or aggrave What decreases or allew What is your goal of treat	ates your sympto viates your symp	oms?	extreme pain), V	Vhat is your le	evel of pain?			

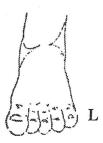
MARK THE AREA (S) BELOW TO IDENTIFY ANY PROBLEMS YOU MAY BE HAVING



By Whom?_



Have you been treated in the past for this problem? Yes____No__





When?



