Foot and Ankle Specialists of San Diego

Robert J. Vallone DPM Kyoung Min Han DPM

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Welcome to our office. Please answer all the questions below. This information is important for your health and our records. If you need help, please do not hesitate to ask.

_____
Last Name First Name Middle

_____
Street Address Apt # City/State/Zip

_____
Home Phone # Cell Phone # Male/Female Marital Status (M,D,W,S)

_____
Email Address

_____
Social Security # Date of Birth Age Drivers License #

_____
Employer Occupation Work Phone #

_____
Spouse's Name Employer Work Phone #

_____
Name of person responsible for payment of account

_____
Name and address of responsible party, if different from patient's address

_____
Name of emergency contact Telephone #

How did you find out about our office ?_____

What is your foot problem ? _____

_____

Pharmacy Name/Location _____

I hereby authorize payment of medical benefits by my insurance company(s) to be made directly to Robert J. Vallone DPM and Kyoung M. Han DPM for service(s) rendered. I understand my bill is due and payable at the time of service unless other arrangements have been made.

I hereby give my permission to Robert J. Vallone D.P.M. and Kyoung M. Han D.P.M. to examine, photograph, administer treatment, and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot problems.

_____
Signature Date

_____
Signature of Guardian or Agent Date

Medical History

Patient Name:_____ **Date:**_____

Primary Physician's Name and Location: _____

Referring Physician's Name and Location:_____

1. **Explain your foot/ankle problem** ☐ Right ☐ Left _____

2. **When did pain/discomfort begin (date):** _____
   Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____
3. **What makes the pain/discomfort better:** _____
4. **Have you had a physical trauma?** ☐ No ☐ Yes _____
5. **Have you had an accident?** ☐ No ☐ Yes _____
6. **Occupation:** _____ **Is your problem work related?** ☐ Yes ☐ No
7. **Past Medical History:**

☐ Anemia	☐ Epilepsy	☐ High Blood Pressure	☐ Osteoarthritis
☐ Bleeding Disorders	☐ Gout	☐ Kidney Disease	☐ Other Arthritis
☐ Blood Clots	☐ Heart Problems	☐ Lung/Respiratory Disorders	☐ Rheumatic Fever
☐ Cancer _____	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Stroke
☐ Diabetes	☐ High Cholesterol	☐ Nerve Disorders	☐ Thyroid Disorders
	☐ HIV / AID	☐ Neurological Disorders	☐ Other: _____

8. **List all medications/herbs/vitamins:** ☐ **NONE** _____
9. **Allergies:** (Describe reaction) ☐ **NONE**

☐ Penicillin _____	☐ Aspirin _____	☐ Narcotic Agent / Codeine _____
☐ Anesthesia _____	☐ Shellfish _____	☐ Sulfa Drugs _____
☐ Nickel / Metal _____	☐ Radiographic Contrast Dye _____	
☐ Latex _____	☐ Other _____	

10. **Are you currently pregnant?** ☐ No ☐ Yes _____
11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No
    Surgery / Date: _____
12. **Social History:** (Only check what is pertinent to you)
    ☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits _____
    ☐ Caffeine Use ☐ Drug use (recreational, IV)

Patient Name:_____ **Date:**_____

13. **Family History: (List relationship of family member(s) who have had these problems):**

☐ Diabetes_____ ☐ Heart Disease _____ ☐ Kidney Disease _____

☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____

☐ Rheumatology _____ ☐ Bleeding Disorders _____ ☐ Cancer _____

☐ Other family History: _____

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses	
☐ Double Vision	☐ Cataract	☐ Dizziness	
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat	
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears	
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma	
☐ Anemia	☐ Skin Lump - Location		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms	
GastroIntestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Joint Pain, Arthralgia	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	