

**Foot & Ankle                      Dr. Walkovich | Dr. Russell | Dr. Denenburg  
Physicians & Surgeons**

**Patient Medical History & Physical**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

How long has it been bothering you? \_\_\_\_\_ Family Physician: \_\_\_\_\_

**Medications & Allergies**

List medications you take regularly:  Check here if you take **no medication**

\_\_\_\_\_

List medications you are allergic or sensitive to:  Check here if **no allergies**

Antibiotics (Penicillin, Sulfa, etc.) \_\_\_\_\_

Other Medicines \_\_\_\_\_

Any problems with local anesthetics (Novocain, Lidocaine)?  Yes  No / Betadine (Iodine)?  Yes  No

Medical Tape?  Yes  No / Aspirin, Ibuprofen (Advil, Motrin)?  Yes  No / Latex?  Yes  No

**Social & Medical History**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Social History: Tobacco Use?  Yes  No  Past / Alcohol Use?  Yes  No / Illicit Drug Use?  Yes  No

Do you have or have you ever had: (please circle) Cancer / COPD / Diabetes / Heart Disease / Hepatitis A, B, or C / High Cholesterol / High Blood Pressure / Kidney Disease / Other: \_\_\_\_\_

List all surgeries you have had: \_\_\_\_\_

**REVIEW OF SYSTEMS (to be completed by office staff only)**

Are you currently pregnant?  Yes  No

Findings: [✓] Normal [+] Abnormal

Details of abnormal findings

General		Abdominal	
Eyes		Lymph	
ENT		Genitourinary	
Respiratory		Musculoskeletal	
Cardiovascular		Skin	
Chest/Breast		Neurological	
Neck		GI	

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Corey B Russell, DPM / Michael J Walkovich, DPM  
Rostislav Denenburg, DPM

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Date