AFFILIATED FOOT & ANKLE SPECIALISTS
OF CLIFTON

Clifton Office:
1117 Rt. 46 East, Suite 203
Clifton, NJ 07013
Ph: 973.365.2208
Fax: 973.777.4895
Jeffrey Miller DPM, FACFAS*

Patient Information Form
(Please Print)

* Board Certified in Foot & Ankle Surgery

Date: ___/___/___

Patient Name:_____ Date of Birth: ___/___/___ Age: ___ Sex: M F

Home Address: _____ City/State: _____ Zip:_____

Home Phone #: (____) _____-_____ Cell Phone #: (____) _____-_____

Work Phone #: (____) _____-_____ E-mail: _____

Please Circle How You Prefer To Be Contacted: Home Phone Work Phone Cell Phone Email

Do You Have A Legal Guardian Or Healthcare Power Of Attorney? Yes No

If Yes, Name: _____ Relationship: _____ Phone #: (____) _____-_____

Emergency Contact: _____ Relationship: _____ Phone #: (____) _____-_____

Primary Care Doctor: _____ Location: _____ Date Last Seen: _____

Pharmacy: _____ Location: _____ Phone #: (____) _____-_____

Is There a Family Member or Other Person You Would Like For Us to Share Your Medical Information With?

_____ Yes Name(s) _____

_____ No

Who Is Responsible For Payment? _____ Relationship to Patient: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (____) _____-_____

Quality Measures:

Height: _____ Weight: _____ Shoe Size: _____ Primary Language: _____

Race:
- ☐ Not Specified
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

Ethnicity:
- ☐ Not Specified
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Patient Name: _____

Date of Birth: _____/____/_____

Please List All Medications You Are Currently Taking:
(Include Prescriptions, Over-The-Counter Medications And Herbal Supplements)

Name	Dose	How Often Do You Take?

Please List All Prior Surgeries:

Type of Surgery	Date	Type of Surgery	Date

Please List All Prior Hospitalizations (Other Than For Surgery):

Reason for Hospitalization	Date	Reason for Hospitalization	Date

Social History:

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No Longer Use ☐ History of Alcohol Abuse

Current Use: ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit- How Long Ago? _____ Type _____

Current Use: ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Recreational Drugs: ☐ Never ☐ Quit- How Long Ago? _____ Type _____

Current Use: ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Employer: _____ Occupation: _____

How Much Are You on Your Feet At Work: 10% 50% 75% 100%

Do Others Depend Upon You For Their Care? ☐ Children Ages(s)_____ ☐ Pet(s) What Kind? _____

☐ Elderly or disabled family members ☐ Other _____

Exercise: ☐ Never ☐ Rarely ☐ Occasional ☐ Weekly ☐ Several Times a Week ☐ Daily

Types of Exercise: _____

Family History:

Do You Have a Family History of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure

☐ Strokes ☐ Coronary Heart Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis

☐ Other _____

Patient Name: _____

Please list all physicians you have seen in the last 5 years and their medical specialty. _____

_____

_____

Your Medical History

Allergies: ☐ None Known ☐ Medications_____

☐ Anesthesia _____ ☐ Foods_____

☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other_____

Have You Ever Had Any of The Following?

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

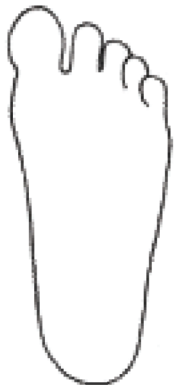
Other Conditions _____

Current Problems

What Specific Problem Brings You to Our Office Today? _____

Where Is The Pain/Problem Located? Please Mark on The Pictures Below.

Top of foot



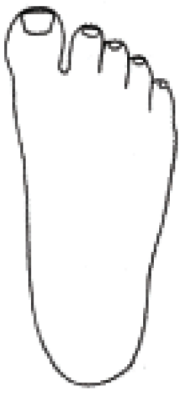
Bottom of foot

Left Foot

Inside of foot

Outside of foot

Top of foot



Bottom of foot

Right Foot

Inside of foot

Outside of foot

Patient Name: _____

Date Of Birth: ____/____/____

How Long Ago Did This Problem First Start? _____ Days/ Weeks/ Months/ Years

Did Your Pain Or Problem: ☐ Begin All of a Sudden ☐ Gradually Develop Over Time

How Would You Describe Your Pain? ☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

☐ Radiating ☐ Itching ☐ Stabbing ☐ Other_____

How Would You Rate Your Pain on a Scale From 1 To 10? (Please Circle) 1 2 3 4 5 6 7 8 9 10

Since The Time Your Pain or Problem Began, Has It:

☐ Stayed The Same ☐ Become Worse ☐ Improved

What Makes Your Pain or Problem Feel Worse? ☐ Walking ☐ Standing ☐ Daily Activities

☐ Resting ☐ Dress Shoes ☐ High Heels ☐ Flat Shoes ☐ Any Closed Toe Shoe

☐ Running ☐ Other _____

What Makes Your Pain or Problem Feel Better? _____

What Treatments Have You Had For This Problem? _____

How Has This Problem Affected Your Lifestyle And Ability To Work? _____

_____

Was This Problem Caused By An Injury? ☐ Yes (Describe) _____ ☐ No

If Yes, Was It a Work-Related Injury? ☐ Yes ☐ No

How Did You Hear About Our Practice? _____

If By Referral, Whom May We Thank For Referring You to Our Office: _____

☐ Search Engine/Website ☐ Facebook ☐ Advertisement ☐ Family or Friend ☐ Physician

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To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____

Print Name of Patient, Parent or Guardian Signature of Doctor

_____ _____

If Other Than Patient, Relationship to Patient Date

_____

Signature

_____

Date