ALEXANDER ORTHOPAEDIC ASSOCIATES

foot & ankle

The skill, experience and advanced solutions to put you back on your feet.

Adam D. Perler, DPM

www.adamperler.com
www.alexanderorthopaedics.com

Advanced Reconstructive Surgery of the Foot and Ankle

Trauma of the Foot and Ankle

Sports Medicine of the Foot and Ankle

Cutting-Edge Conservative Treatments of the Foot and Ankle

Children's Foot Disorders

Regenerative Medicine & Stem-Cell Therapy

Total Ankle Joint Replacement

Peripheral Nerve Disorders

Gait and Running Analysis

Arch and Heel Pain

Dance Medicine

Welcome to Alexander Orthopaedic Associates

Thank you for selecting our office for your foot and ankle health care needs. We have prepared this packet of information and patient forms in order to help make your visit a convenient and pleasant experience.

Prior to your appointment, please contact your insurance company to clarify your insurance coverage requirements.

When you come for your appointment, please bring the following:

- ☐ **Written Referral** (If required by your insurance company)
- ☐ **Completed *Registration Form***
- ☐ **Completed *History Form***
- ☐ **Medical Insurance card**
- ☐ **Previous x-rays and medical records, if applicable**
- ☐ **Your primary care (or referring) physician's name and office phone and fax number**
- ☐ **Shoes** (bring a sample, only need one shoe per pair, of the more common shoes you wear - including athletic, work and/or walking shoes)
- ☐ **Current set of orthotics or braces**

Note: As you will be receiving advice on the proper shoes for your feet, we recommend that you do not purchase any new shoes prior to your visit.

Please be prepared to pay for the following at the time of your visit:

- ☐ **Co-Payment (if applicable)**
- ☐ **Deductible (If not fully paid for this year)**
- ☐ **If no insurance, the full cost of visit**

For your convenience, we do accept Visa and Mastercard.

Our entire staff is here to help you in whatever manner we can. We look forward to serving you in the near future.

Your Scheduled Appointment is for:

_____ at _____AM PM

As a courtesy to other patients who are waiting to get in, please call at least 24 hours in advance if you must cancel your appointment. We reserve the right to charge for missed appointments.

Please allow plenty of time for traffic in order to be on the time for your appointment. Arrive 15 minutes prior to your appointment if forms are complete. Arrive 30 minutes prior if forms are not complete.

Adam D Perler, DPM, FACFAS

Podiatric Medicine

Foot and Ankle Reconstructive Surgery

Room # _____

Xray Taken:_____

XR/MRI Brought: Y N

PATIENT HISTORY - Please print and fill out completely

Name: _____ **Date of Birth**: _____

Age: _____ **Height**: _____ **Weight**: _____ **Shoe Size**: _____ **Hand Dominance**: ___L ___R

Primary Care Physician: _____ **Doctor's Phone &/or Fax #:** (___)_____

Email: _____ **How did you hear about us?** _____

Pharmacy name, address and phone number: _____

HISTORY OF INJURY/COMPLAINT

Please briefly describe the problem you are experiencing:

_____

_____

- **Side:** □ Right □ Left □ Both **Area of symptoms:** □ Ankle □ Achilles Tendon □ Heel □ Foot □ Toes
- **Did your problem result from a specific injury/accident?** ___ Y ___ N Injury/Accident Date: _____
- **How long have you had your condition/problem?** _____
- **Please rate your current pain/discomfort on a scale of 1-10** (1 – painful; 10 – extreme pain) _____
- **Is the pain:** □ Constant □ Occasional □ Sharp □ Dull □ Aching □ Throbbing □ Stabbing
- **What symptoms are you experiencing?** □ Burning □ Tingling □ Numbness □ Popping □ Giving Way □ Grinding □ Other:
- **What, if anything, makes your symptoms better?** _____
- **What, if anything, makes your symptoms worse?** _____
- **Have you seen another physician for this condition/injury?** ___ Y ___ N If yes, who? _____
- **What treatments have you tried?** □ Nothing □ Physical Therapy □ Exercise □ Acupuncture □ Chiropractic □ Injections □ Ice and/or Heat □ Medication: _____ □ Other: _____
- **Have you had any of the following tests for your condition/injury?** □ X-Rays □ MRI Scan □ CT Scan □ EMG/NCV □ Blood Test

PAST MEDICAL HISTORY

Please check all that apply:

□ Glaucoma	□ Liver/Gallbladder	□ Sickle Cell Anemia	□ Neuropathy
□ Dentures	□ Hepatitis: A B C	□ Blood Transfusions	□ Cancer: _____
□ Heart Disease	□ Kidney Disease	□ HIV/AIDS	□ Psychiatric Disorder
□ Heart Murmur	□ Bladder Disorder	□ Arthitis: Gen or Rheumatoid	□ Skin Disorder
□ High Blood Pressure	□ Diabetes: ____ years	□ Bone/Joint Disorder	□ Keloid Formation
□ Rheumatic Fever	□ Diet-controlled	□ Low Back Problems	□ Chemical Dependency
□ Stroke	□ Oral Medication	□ Gout	□ Alcoholism
□ Poor Circulation	□ Insulin Dependent	□ Epilepsy/Seizures	□ Pregnancy # _____
□ Asthma	□ Thyroid Disease	□ Neurological Condition	□ Births # _____
□ COPD/Emphysema	□ Bleeding Disorder	□ History of Blood Clots	□ Other _____

HOSPITALIZATION and SURGICAL HISTORY

DATE:	REASON:	COMPLICATIONS:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any complications with anesthesia in the past? □ **Yes** □ **No** **If yes, what type?**

CURRENT MEDICATIONS

Please write additional medications on a separate sheet of paper if there is not enough room provided.

MEDICATION:	DOSAGE:	FREQUENCY:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Are you allergic to any medications? □ **Yes** □ **No** **Are you allergic to**: □ Sulfa □ Latex □ Penicillin □ Other: _____

Please specify the type of reaction you had to the above medication(s): _____

FAMILY HISTORY

Please check all that apply and circle any family member affected.

DISEASE:	FAMILY MEMBER:	DISEASE:	FAMILY MEMBER:
□ **Heart Disease**	Mother Father Sibling Child	□ **Blood Clots**	Mother Father Sibling Child
□ **High Blood Pressure**	Mother Father Sibling Child	□ **Stroke**	Mother Father Sibling Child
□ **Rheumatoid Arthritis**	Mother Father Sibling Child	□ **Anesthesia Reaction**	Mother Father Sibling Child
□ **Diabetes**	Mother Father Sibling Child	□ **Similar Foot Problems**	Mother Father Sibling Child
□ **Cancer/Tumor**	Mother Father Sibling Child		
Type:	_____		

SOCIAL HISTORY

What kind of work do you do? (Example: Student, secretarial, construction, teaching) _____

Where do you work or attend school (include grade/level)? _____

What kinds of physical demands do you have on your feet due work, school, or other activities? _____

What type of shoes do you typically wear? _____

Does your problem limit your work or activities? □ Yes □ No **If yes, how much?** _____

How would you describe your daily activity level? □ Active □ Moderately Active □ Not Active

Do you exercise regularly? □ Yes □ No **If yes, what type of activity and how often?** _____

Are you on a special diet? □ Yes □ No **If yes, restrictions?** _____

Do you smoke? □ Yes □ No □ Quit **If yes, how many packs per day?** _____ **For how long?** _____

Do you drink? □ Yes □ No □ Quit **If yes, how often?** (Number) _____ **drinks per week**

Do you or have you used recreational drugs? □ Yes □ No **If yes, what type?** _____ **How often?** _____

When was the Date of last physical examination? _____ **Performed by**: _____