***foot & ankle***

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

**Adam D. Perler, DPM**

[www.adamperler.com](http://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.

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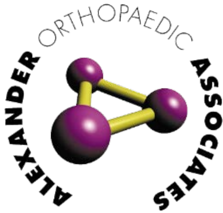
Your Scheduled Appointment is for:

________________ 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 # ____________
X-ray taken ____________
XR/MRI brought yes no
Facility ____________

## PATIENT HISTORY - Please print and fill out completely

**Name:**______________________________**Date of Birth:**__________**Today's Date:** ___________

**Age:** ____**Height:**______**Weight:**_______**Shoe Size:**________ **Hand Dominance:** ◻ Right ◻ Left

**Primary Care Physician:**__________________**Doctors Phone/Fax #s:** _________________________

**Email:**______________ **Pharmacy name, address and phone number:** ________________________

**How did you hear about us?** ☐Doctor Referral ☐Internet Research ☐Friend/Family ☐Workers Comp

☐Urgent Care/ER ☐AOA Website ☐adamperler.com Website ☐Insurance Referral ☐Other

**Ethnicity/Race?** ☐Caucasian ☐Hispanic ☐African American ☐Asian ☐Other ______________

## HISTORY OF CURRENT CONDITION

**Why are you here for an evaluation today?** (It is important to fill out this section to the best of your ability)

_____________________________________________________________________________

_____________________________________________________________________________

**Is the condition the result of an injury?** ◻ Yes ◻ No **If yes, what was the date of the injury?** ____________

**The injury occurred during:** ◻ sports injury ◻ motor vehicle accident ◻ work ◻ other _______________

**Please describe how the injury occurred:** __________________________________________________

**How do you rate your pain?** (No Pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe Pain)

**Is the pain:** ◻ Constant ◻ Occasional ◻ Sharp ◻ Dull ◻ Aching ◻ Burning ◻ Throbbing ◻ Stabbing

◻ worse in the am ◻ worse at pm ◻ present in bed ◻ worse with the first few steps out of bed ◻ worse with walking/standing

**What symptoms are you experiencing?** ◻ Burning ◻ Tingling ◻ Numbness ◻ Popping ◻ Giving Way ◻ Grinding

**How long have you had this problem? (#)** _______________ ◻ Days ◻ Weeks ◻ Months ◻ Years

**Have you experienced this problem in the past?** ◻ Yes ◻ No

**What makes your symptoms better?** ______________________________________________________

**What makes your symptoms worse?** ______________________________________________________

**What treatments have you tried?** ◻ Rest ◻ Ice/heat ◻ Bracing/Arch Supports ◻ Injections ◻ Physical Therapy

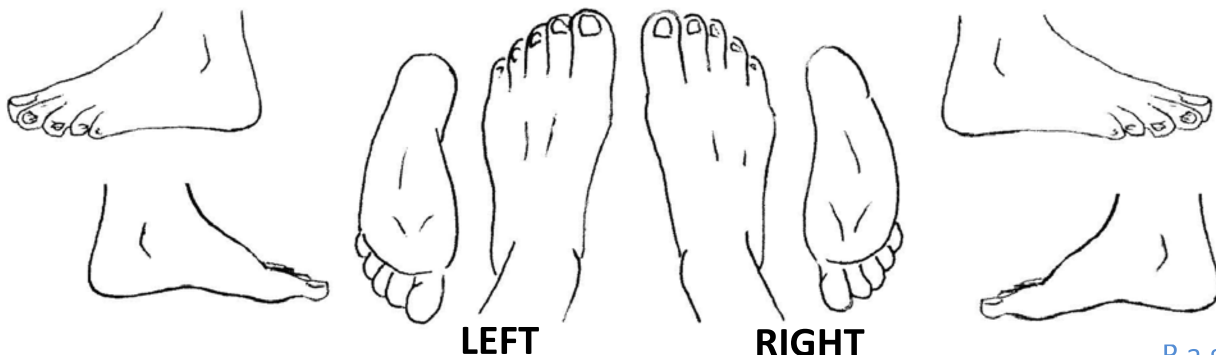
Medication:_____________________________Other: ______________________________________________

**Have you had any of the following tests?** ◻ X-Rays ◻ MRI Scan ◻ CT Scan ◻ EMG/NCV ◻ Blood Test

**Have you seen another foot/ankle doctor for this problem?** ◻ No ◻ Yes Who: ____________________

**Do you have any history of any prior foot/ankle injuries?** ◻ No ◻ Yes: ____________________________

**Please mark the site of your pain/problem with an "X":**



**LEFT** **RIGHT**

## PAST MEDICAL HISTORY (please check all that apply)

☐ Glaucoma
☐ Dentures
☐ Heart Disease
☐ Heart Murmur
☐ High Blood Pressure
☐ Rheumatic Fever
☐ Stroke
☐ Poor Circulation
☐ Asthma
☐ COPD/Emphysema

☐ Liver Disease
☐ Hepatitis: A B C
☐ Renal Disease
☐ Pacemaker/Stimulator
☐ Diabetes:__years
- o Diet-controlled
- o Oral Medication
- o Insulin Dependent

☐ Thyroid Disease
☐ Bleeding Disorder

☐ Sickle Cell Anemia
☐ HIV/AIDS
☐ Arthitis: Gen or
☐ Bladder Disorder
☐ Bone/Joint Disorder
☐ Low Back Problems
☐ Gout
☐ Epilepsy/Seizures
☐ Neurological Condition
☐ History of Blood Clots

☐ Neuropathy
☐ Cancer: _________
☐ Psychiatric Disorder
☐ Skin Disorder
☐ Keloid Formation
☐ Chemical Dependency
☐ Alcoholism
☐ Pregnancy # _____
☐ Births # ________
☐ Other __________

## MEDICATIONS (Please include any supplements and vitamins)

**Current Medications** (name, strength and dose):

1.________________________________ 4.___________________________ 7.____________________________

2.________________________________ 5.___________________________ 8.____________________________

3.________________________________ 6.___________________________ 9.____________________________

## ALLERGIES (please also list any drug intolerances)

**Are you allergic to any medications? NO YES** □ Sulfa □Latex □Penicillin □Tape □ Codeine □ Other: ________

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

## LIST ALL PREVIOUS HOSPITALIZATIONS/SURGERIES

☐ **None**

| **Procedure** | **Complications** | **Year** |
|---|---|---|
| ______________________________ | __________________________________ | _____________ |
| ______________________________ | __________________________________ | _____________ |
| ______________________________ | __________________________________ | _____________ |
| ______________________________ | __________________________________ | _____________ |

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

## FAMILY HISTORY (check all that apply and circle any involved family members)

| DISEASE: | FAMILY MEMBER: |
| --- | --- |
| ☐ Heart Disease | Mother Father Sibling Child |
| ☐ High Blood Pressure | Mother Father Sibling Child |
| ☐ Rheumatoid Arthritis | Mother Father Sibling Child |
| ☐ Diabetes | Mother Father Sibling Child |
| ☐ Cancer/Tumor | Mother Father Sibling Child |

| DISEASE: | FAMILY MEMBER: |
| --- | --- |
| ☐ Blood Clots | Mother Father Sibling Child |
| ☐ Stroke | Mother Father Sibling Child |
| ☐ Anesthesia Reaction | Mother Father Sibling Child |
| ☐ Similar Foot Problems | Mother Father Sibling Child |

## SOCIAL HISTORY

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

**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 *prior* to your injury?** ☐ 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) ________

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

## REVIEW OF SYMPTOMS (these are symptoms you are currently experiencing)

**GENERAL**
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss >10

**SKIN**
- ☐ Nail Changes
- ☐ New Lesions/ulcers
- ☐ Frequent Rashes
- ☐ Skin Color Changes

**ENT**
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Decreased Hearing
- ☐ Earache
- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Sore Throat

**NECK**
- ☐ Neck Pain
- ☐ Swollen Glands

**RESPIRATORY**
- ☐ Chronic Cough
- ☐ Decreased Exercise Tolerance
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Sputum Production
- ☐ Wheezing

**CARDIOVASCULAR**
- ☐ Chest Pain
- ☐ Leg Pains with walking
- ☐ Leg Swelling
- ☐ Night Awakening due to
- ☐ trouble Breathing
- ☐ Palpitations
- ☐ Shortness of Breath

**GASTROINTESTINAL**
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn/Ulcers
- ☐ Difficulty Swallowing

**GENITOURINARY**
- ☐ Vaginal Discharge
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Urinary Retention

**MUSCULOSKELETAL**
- ☐ Decreased Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Muscle Aches/Pains

**NEUROLOGICAL**
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing Out
- ☐ Seizures
- ☐ Tremor

**PSYCHIATRIC**
- ☐ Anxiety/Depression
- ☐ Change in Sleep Pattern
- ☐ Hallucinations
- ☐ Suicidal Thoughts

**ENDOCRINE**
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction

**HEMATOLOGY**
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

**Are You Pregnant**
☐ Yes ☐ No

**Are you claustrophobic**
☐ Yes ☐ No

# PATIENT ASSESSMENT

The physicians at Alexander Orthopaedic Associates are concerned about your orthopaedic health and want to make sure that we are evaluating those factors which may impact your orthopaedic wellbeing. The following questions are intended to give the physicians at Alexander Orthopaedic Associates information about your general health.

**Please circle the correct answer or fill in the blanks.**

1. What is your height _________ and weight _________ Prefer not to answer
2. Have you had a Bone Density Study (Dexa scan) for osteoporosis at least once since age 60? □ **Yes** □ **No**
   - If yes, in what year did you have the most recent Bone Density Study or Dexa scan? **Year:** _________
3. Have you been on medicine to treat osteoporosis? □ **Yes** □ **No**
   - If yes, has it been prescribed within 12 months? □ **Yes** □ **No**
   - What medicine are you taking to treat your osteoporosis? ______________________________________
4. Do you take Calcium and Vitamin D? □ **Yes** □ **No**
5. Have you ever had a fracture of your arm, hip, or spine? □ **Yes** □ **No**
6. Have you fallen more than twice or fallen and hurt yourself in the past year? □ **Yes** □ **No**
7. Have you had the influenza vaccination for the current flu season? □ **Yes** □ **No**
8. Have you ever had the pneumococcal vaccine? □ **Yes** □ **No**
9. Do you have an Advanced Care Plan? □ **Yes** □ **No**

***Please understand that smoking and consuming alcoholic beverages can impair your general health as well as your orthopaedic health.***

10. Have you used or smoked tobacco products in the last 24 months? □ **Yes** □ **No**
    - If yes, are you a tobacco smoker? □ **Yes** □ **No**
    - Are you interested in quitting? □ **Yes** □ **No**
11. Do you consume alcoholic beverages? □ **Yes** □ **No**
    - If yes, how much per setting? _____________ Per week? _______________

Print name: ______________________________________________ Date: ______________

Patient signature: _________________________________________