COASTAL

FOOT & ANKLE SPECIALISTS, LLC

MEDICAL HISTORY / ACCIDENT REPORT

DATE:_____ DATE OF BIRTH: _____ AGE: _____

PATIENT FULL NAME: _____

Reason for seeing doctor today (Please be specific): _____

Date of injury/accident: _____

Where did injury/accident occur? _____

Is there other insurance that will pay this bill (Auto, Workers' Comp, etc.): _____ YES _____ NO

If so, what insurance: _____ Was this job related? _____ YES _____ NO

Have you had xrays? _____ YES _____ NO Where and what date? _____

*CURRENT MEDICATIONS (ASK FRONT DESK TO COPY LIST IF YOU HAVE ONE, WE WILL ATTACH IT WITH YOUR FILE)

_____

_____

_____

_____

_____

DO YOU HAVE CURRENT OR PAST HISTORY OF THE FOLLOWING?

(EVEN IF YOU ARE NOT CURRENTLY TAKING MEDICATION FOR THESE)

____ Kidney Disease/Dialysis	____ Emphysema	____ Depression
____ High Cholesterol	____ High Blood Pressure	____ HIV
____ Heart Disease	____ Ulcers	____ Thyroid Disorder
____ Anesthesia Reaction	____ Hepatitis	____ Asthma
____ Diabetes	____ Pacemaker	____ Other _____

Have you ever been treated for an orthopedic injury? ___ YES ___ NO _____

ALLERGIES: _____

List ANY Surgical Procedure you have had in PAST and Name of Surgeon: _____

_____

Do you smoke? If so how many cigarettes? _____ YES _____ NO _____ AMOUNT per day/week/month

Do you drink alcohol? If so how often? _____ YES _____ NO ___ daily ___ weekly ___ monthly ___ ocassionally

What is your Occupation? _____

Are you PREGNANT? If so how many weeks? _____ YES _____NO _____ Weeks

REVIEW OF SYMPTOMS

Have you experienced the following?

_____ Chest Pain	_____ Cough	_____ Dizziness
_____ Muscle/Joint pain	_____ Shortness of Breath	_____ Urinary Difficulty
_____ Other: _____		

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