Dr. Camilleri, DPM
Dr. Oaks, DPM
Dr. Komarov, DPM

Ridgeland Foot & Ankle Center

RidgelandFoot.com
6845 STANLEY AVE. BERWYN, IL 60402
T: (708) 788-5232 F: (708) 788-3618

Chart #: ____________________ **Print Patient Name:** ____

MEDICAL HISTORY

WHAT BROUGHT YOU TO SEE THE DOCTOR? (Please provide a brief description of the nature of the illness / injury.)

WHEN DID YOUR SYMPTOMPS BEGIN?

WHAT TREATMENTS HAVE YOU TRIED?

WHAT OTHER FOOT / ANKLE / LEG PROBLEMS DO / DID YOU HAVE?

ALLERGIES: Do you have any allergies?	1.	2.	3.

MEDICATIONS: What medications are you currently taking?

1.	6.	11.	16.
2.	7.	12.	17.
3.	8.	13.	18.
4.	9.	14.	19.
5.	10.	15.	20.

PAST MEDICAL HISTORY

Indicate whether you have had any of the following medical problems:

	Yes	No		Yes	No
Heart Disease			Arthritis		
Heart Valve Replacement			Gout		
Heart Attack			Fibromyalgia		
Chest Pain			Osteoporosis		
Pacemaker			Leg Pain		
High Blood Pressure			Back Pain		
High Cholesterol			Weakness In Extremities		
Stroke			Numbness In Extremities		
Shortness Of Breath			Balance Problems		
Lung Disease			Dizziness		
Asthma			Headaches/Migraines		
Sleep Apnea			Changes/Loss Of Vision		
Liver Disease			Stomach Ulcer		
Hepatitis			Tuberculosis		
Bleeding Disorder			HIV		
Clotting Disorder			Cancer (Type?)		
Anemia			Thyroid Condition		
DVT (Blood Clot)			Pregnant		
Kidney Disease			Diabetes		
Fractures (When/Where?)			Type I ___ Type II ___		
Joint Replacement (Which?)			Skin Conditions (What?)		

FAMILY HISTORY

Check if any family members have/had any of the following:

	Yes	No		Yes	No
Bleeding Disorder			Gout		
Cancer			Arthritis		
Heart Trouble			Bunion		
High Cholesterol			Bunionette		
High Blood Pressure			Flat Feet		
Stroke			High Arched Feet		
Diabetes			Pigeon-Feet		

Other (Please specify):

SOCIAL HISTORY

	Yes	No	what kind,how much, how often?
Do you smoke?			
Did you ever smoke?			
Caffeine? (tea /coffee)			
Illicit drug use?			
Alcohol use? (Current or past)			
Exercise regularly?			

PAST SURGICAL HISTORY

Procedure	Date	Surgeon	Complication
1.			
2.			
3.			
4.			

HEIGHT: __________________________ **WEIGHT:** _____________________ **SHOE SIZE:** __________________

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION PROVIDED IS TRUE AND ACCURATE AND I HAVE DISCLOSED ALL PERTINENT MEDICAL HISTORY.

_______________________________________ _______________________

Patient Signature Date

_______________________________________ _______________________

Patient's Guardian or Representative's Signature
IF PATIENT IS A MINOR (UNDER 18) OR UNABLE TO SIGN OWN CONSENT

Relationship
IF SIGNED BY PATIENT'S GUARDIAN OR REPRESENTATIVE