Frontier Foot & Ankle Specialists

Ann Wolford, DPM, FACPM
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Patient Name: _____ _____ _____ (**Male/Female**)
First Middle Last

Address: _____**City:**_____ **State:** ___ **Zip:**_____

Phone: (_____) _____-_____ **Email:** _____

Date of Birth: ____/_____/_____ **Age:** _____ **SSN:**_____-_____-_____

Employer: _____ **Occupation:** _____

Height: _____ **Weight:**_____ **Shoe size:** _____

(Complete only if you are insured under your guardian/spouse's insurance plan)
Name:_____ Date of Birth:_____
SSN: _____ Relationship to Patient:_____

Emergency Contact:
Name:_____ Phone:_____
Relationship to patient:_____

Circle:
Married, Single, Widowed

White/Caucasian, Asian, African American, Hispanic/Latino, Other (_____)

Level of Education: High School, GED, College, Graduate/Doctorate

Primary Care/Family Physician:
Physician Name:_____Phone:_____

Preferred Pharmacy:_____Phone:_____

How did you hear about us?
_____Doctor Referral (name:_____)
_____Friend/Family Member
_____Internet Search
_____Website
_____Social Media
_____Other (_____)

Reason for Visit (Please describe nature of your pain or problem):

_____

_____

_____

_____

Past Medical History:

_____Anemia
_____Anxiety
_____Arthritis
_____Asthma
_____Back Pain
_____Bleeding Disorder
_____Blood Clot (DVT/PE)
_____Cancer
_____Coronary Artery Disease
_____Depression
_____Diabetes
_____Dialysis
_____Edema (Leg swelling)
_____Fibromyalgia
_____GI problems
_____Gout
_____Heart Attack
_____Heart disease
_____Hepatitis
_____High Cholesterol
_____HIV/AIDS
_____Hypertension
(high blood pressure)
_____Kidney disease
_____Liver disease
_____Lung disease
_____Osteoporosis
_____Pacemaker/defibrillator
_____PVD (poor circulation)
_____Rheumatoid Arthritis
_____Seizures/epilepsy
_____Skin cancer
_____Stroke
_____Substance Abuse
_____Thyroid Problems
_____Ulcers (Foot or leg)
_____Varicose Veins
_____Other (_____)

Allergies:

_____No known allergies
_____Penicillin
_____Sulfa
_____Other Antibiotics
_____Iodine/Shellfish/Contrast Dye
_____Tape/Adhesives
_____Latex

Family History: (Please list relationship--mother/father/sibling/grandparent)

_____Diabetes-_____
_____Heart disease-_____
_____Hypertension-_____
_____Cancer-_____
_____Stroke-_____
_____Arthritis-_____

Do you smoke/use tobacco, or have you smoked in the past? Yes/No

How much?_____For how many years?_____

If you quit, when?_____ For how many years did you smoke?_____

Do you drink alcohol? Yes/No

How many drinks/week?_____

Do you use e-cigarettes/vape? Yes/No

Do you use illicit or recreational drugs? Yes/No

Surgical History: (please list with year performed)

_____

_____

Medications: (please list with dosage if known, or provide a list)

_____ _____

_____ _____

_____ _____