



**MID LAKE**  
FOOT AND ANKLE

Breanna J. Ferguson, DPM, FACFAS

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## Medical Intake Form

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

### Major Medical Conditions (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Type 1 Diabetes                    | <input type="checkbox"/> Type 2 Diabetes                    |
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Hyperlipidemia (High Cholesterol)  |
| <input type="checkbox"/> Coronary Artery Disease (CAD)      | <input type="checkbox"/> Congestive Heart Failure (CHF)     |
| <input type="checkbox"/> Atrial Fibrillation (A-Fib)        | <input type="checkbox"/> Peripheral Artery Disease (PAD)    |
| <input type="checkbox"/> Stroke or TIA (Mini-stroke)        | <input type="checkbox"/> Deep Vein Thrombosis (DVT)         |
| <input type="checkbox"/> Pulmonary Embolism (PE)            | <input type="checkbox"/> COPD / Emphysema                   |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Chronic Kidney Disease (CKD)       |
| <input type="checkbox"/> Kidney Stones                      | <input type="checkbox"/> Liver Disease / Hepatitis          |
| <input type="checkbox"/> Enlarged Prostate / BPH            | <input type="checkbox"/> Thyroid Disorder (Hypo/Hyper)      |
| <input type="checkbox"/> Adrenal Disorder                   | <input type="checkbox"/> Pituitary Disorder                 |
| <input type="checkbox"/> PCOS (Polycystic Ovary Syndrome)   | <input type="checkbox"/> Glaucoma / Eye Disorders           |
| <input type="checkbox"/> Cancer (specify): _____            | <input type="checkbox"/> Peripheral Neuropathy              |
| <input type="checkbox"/> Seizures / Epilepsy                | <input type="checkbox"/> Bleeding / Clotting Disorders      |
| <input type="checkbox"/> Depression                         | <input type="checkbox"/> Anxiety                            |
| <input type="checkbox"/> Bipolar / Schizophrenia            | <input type="checkbox"/> Lupus (SLE)                        |
| <input type="checkbox"/> Rheumatoid Arthritis (RA)          | <input type="checkbox"/> Psoriatic Arthritis                |
| <input type="checkbox"/> Multiple Sclerosis (MS)            | <input type="checkbox"/> Crohn's / Ulcerative Colitis (IBD) |
| <input type="checkbox"/> HIV / AIDS                         | <input type="checkbox"/> Sleep Apnea                        |
| <input type="checkbox"/> Osteoporosis                       | <input type="checkbox"/> GERD / Acid Reflux                 |
| <input type="checkbox"/> Anemia                             | <input type="checkbox"/> Migraine or Chronic Headaches      |
| <input type="checkbox"/> Obesity                            | <input type="checkbox"/> Alcohol or Substance Use Disorder  |
| <input type="checkbox"/> Other: _____                       |   |



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**Medical Intake Form (Continued)**

**Major Surgical Procedures (check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Bypass Surgery (CABG)   | <input type="checkbox"/> Heart Stent Placement / Angioplasty |
| <input type="checkbox"/> Pacemaker or Defibrillator Implant  | <input type="checkbox"/> Valve Replacement / Heart Surgery   |
| <input type="checkbox"/> Appendectomy  | <input type="checkbox"/> Gallbladder Removal                 |
| <input type="checkbox"/> Hernia Repair   | <input type="checkbox"/> Hysterectomy                        |
| <input type="checkbox"/> Cesarean Section (C-section)  | <input type="checkbox"/> Prostate Surgery (e.g., TURP)       |
| <input type="checkbox"/> Joint Replacement (Hip, Knee, Shoulder)                                   | <input type="checkbox"/> Spine Surgery (Neck, Back, etc.)    |
| <input type="checkbox"/> Carpal Tunnel Release   | <input type="checkbox"/> Cataract Surgery                    |
| <input type="checkbox"/> Tonsillectomy / Adenoidectomy   | <input type="checkbox"/> Bariatric (Weight Loss) Surgery     |
| <input type="checkbox"/> Kidney Transplant / Nephrectomy   | <input type="checkbox"/> Liver Transplant                    |
| <input type="checkbox"/> Amputation (specify): _____   |  |
| <input type="checkbox"/> Cancer-related Surgery (specify): _____                                   |  |
| <input type="checkbox"/> Other (please list all other surgeries below):<br>_____<br>_____<br>_____ |  |

**Family History (check all that apply):**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Cancer       |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other: _____ |



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**Medical Intake Form (Continued)**

**Allergies (medications, food, latex, etc.)**

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**Social History:**

Marital Status:

- Single       Married       Divorced       Widowed

Occupation: \_\_\_\_\_

Alcohol Use:

- Yes       No

If yes, how often? \_\_\_\_\_

Tobacco Use:

- Current       Former       Never

Drug Use:

- Yes       No

If yes, what type? \_\_\_\_\_

**Preferred Pharmacy:**

\_\_\_\_\_  
Pharmacy Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code