COASTAL
FOOT & ANKLE SPECIALISTS, LLC

Dr. Larry B. Dyal, Jr.
Dr. Gary Grolemund
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MEDICAL HISTORY / ACCIDENT REPORT

Today's Date: ________________________ Date of Birth: _____________ Age: ________

Patient Full Name: _______________________________________

Reason for seeing the doctor today (*please be specific – what happened*?): ___________________________________

Date of injury/accident: _______________

Where did injury/accident occur? ____

Is there other insurance that will pay this bill (ie. AUTO, WORKERS' COMP): ___ YES ______ NO

If so, what insurance?: ___________________________________ Was this job-related? ______YES___ NO

Have X-Rays been made?

Current Medications: (include dosage and frequency)

Do you have past or current history of the following: (Please check **ONLY** the ones that apply.)

(EVEN IF YOU ARE NOT CURRENTLY TAKING MEDICATION FOR THE PROBLEM)

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

Have you ever been treated for any prior orthopedic injuries? ____

Allergies: ____

List **ANY** surgical procedures you have had in the past and the name of the surgeon: __________________________

____

Do you smoke? How many cigarettes per day? _____________________

Do you drink alcohol? How much? _________________________

Occupation: _________________________

Are you pregnant? ___________________

REVIEW OF SYMPTOMS

(Have you experienced the following?)

_____ Chest Pain
_____ Cough
_____ Dizziness
_____ Muscle or joint pain
_____ Shortness of breath
_____ Urinary difficulty
_____ Other: ____

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