DR. SHANE D. DRAPER
DR. QUINN D. LINDSTROM
FOOT AND ANKLE SPECIALIST

Name: _____

Email: _____

Date of Birth: _____

Marital Status: M S D W

Medical history/ Chronic illness: _____

Surgical history: _____

_____

Drug Allergies: _____

Medications and dosages: _____

_____

# of Children: _____

(Please Circle)

Employed: Full time Part time Retired Student

Nutrition: Excellent Good Average Poor

Exercise: Walking Cardio Weights **Frequency:** Regular Occasional Never

Smoking: Yes/No

Current- Amount _____

Former- Quit Date _____

Alcohol: Yes/No Amount _____ **Illicit Drugs:** Yes/No

Family Illnesses and Medical History

Mother: Living/Deceased _____

Father: Living/Deceased _____

Siblings: Brothers: _____ Sisters: _____

FamilyHistory: _____

Signed form for **DNR** (Do Not Resuscitate) **Yes / No**

1995 Errecart Boulevard, Suite 200
Elko, Nevada 89801
775-738-1100 TEL
775-738-1101 FAX
shanedraper@frontiernet.net