

Patient Medical History

Patient Name: _____ Date of Birth: _____

What is your foot or ankle problem? _____

For how long have you had the problem? _____

Have you been treated for it? Yes No If yes, by whom? _____

Past Medical History

Have you ever had the following:

- | | | | |
|--|--|--|--|
| Athlete's Foot <input type="checkbox"/> | Cerebral Palsy <input type="checkbox"/> | Pacemaker <input type="checkbox"/> | Dialysis <input type="checkbox"/> |
| Fungal toenails <input type="checkbox"/> | Gout <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Eczema <input type="checkbox"/> |
| Ankle Sprains <input type="checkbox"/> | Arthritis <input type="checkbox"/> | Stroke <input type="checkbox"/> | Psoriasis <input type="checkbox"/> |
| Bunions <input type="checkbox"/> | If yes, what type? _____ | High cholesterol <input type="checkbox"/> | Epilepsy <input type="checkbox"/> |
| Hammertoes <input type="checkbox"/> | Fibromyalgia <input type="checkbox"/> | Peripheral arterial disease <input type="checkbox"/> | Migraines <input type="checkbox"/> |
| Corns/Calluses <input type="checkbox"/> | Artificial Joints <input type="checkbox"/> | Varicose Veins <input type="checkbox"/> | Glaucoma <input type="checkbox"/> |
| Foot ulcer <input type="checkbox"/> | Back Trouble <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> | Cataracts <input type="checkbox"/> |
| Flat Feet <input type="checkbox"/> | If yes, what type? _____ | Asthma <input type="checkbox"/> | Venereal Disease <input type="checkbox"/> |
| Foot/Ankle Fracture <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> | Thyroid problems <input type="checkbox"/> | HIV Positive <input type="checkbox"/> |
| Heel Pain <input type="checkbox"/> | Leg Length Difference <input type="checkbox"/> | Hepatitis <input type="checkbox"/> | Alzheimer's <input type="checkbox"/> |
| Ingrown Toenails <input type="checkbox"/> | Cancer <input type="checkbox"/> | If yes, what type? _____ | Schizophrenia <input type="checkbox"/> |
| Plantar's Warts <input type="checkbox"/> | If yes, what type? _____ | Stomach ulcer <input type="checkbox"/> | Depression <input type="checkbox"/> |
| Blood clot in leg <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Acid Reflux <input type="checkbox"/> | Bipolar Disorder <input type="checkbox"/> |
| Blood clot in lung <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> | Irritable Bowel Syndrome <input type="checkbox"/> | Autism <input type="checkbox"/> |
| Foot/Ankle Infections <input type="checkbox"/> | Scarlet Fever <input type="checkbox"/> | Crohn's Disease <input type="checkbox"/> | Anything else (please list) _____ |
| Problems with Anesthetics <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Hernia <input type="checkbox"/> | Do you take antibiotics before dental or surgical procedures? <input type="checkbox"/> |
| Blood or Plasma Transfusion <input type="checkbox"/> | Artificial Heart Valves <input type="checkbox"/> | If yes, what type? _____ | |
| Anemia <input type="checkbox"/> | Mitral Valve Prolapse <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | |
| Polio <input type="checkbox"/> | | Liver Disease <input type="checkbox"/> | |
| Parkinson's <input type="checkbox"/> | | | |

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, city, state
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Care Physician: _____ Date of last physical exam: _____

Patient Social History

- Marital Status: Single Married Separated Divorced Widowed
- Do you exercise? Yes No If yes, how often? _____ What kind of exercise? _____
- Do you drink alcohol? Yes No If yes, how many? _____ per Day Week Month Year
- Do you use tobacco? Yes No If yes, how many packs per day? # _____ for # _____ years.
- Do you have a history of using street drugs? Yes No If yes, what street drug(s)? _____
- What is your occupation? _____ What are your activities at work? _____
- What shoes do you wear? _____ Shoe size? _____

Family Medical History

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

- Heart Disease _____ Cancer _____ If yes, what type? _____
 Arthritis _____ If yes, what type? _____ Diabetes _____
 Neurological Problems _____ Foot Problems _____ If yes, what type? _____
 Blood clot in leg _____ Blood clot in lung _____
 Any other family medical history _____

Review of Systems: Do you **currently** have any of the following?

General

- Good general health lately
- Recent weight increase
- Recent weight decrease
- Fatigue
- Fever
- Headaches

Skin

- Rash or itching
- Lumps
- Sores
- Dryness
- Changes in hair or nails
- Change in skin color
- Foot odor

Eyes

- Wear glasses/contacts
- Eye drainage

Ears/Nose/Mouth/Throat

- Poor Hearing
- Dizziness
- Earaches or drainage
- Sinus problems
- Nosebleeds
- Sore throat
- Bleeding gums
- Mouth sores

- Dentures
- Dry mouth
- Strange taste or loss in taste

Neck

- Lumps
- Swollen glands
- Pain or stiffness

Respiratory

- Chronic or frequent cough
- Difficulty breathing

Cardiovascular

- Chest pain or discomfort
- Shortness of breath
- Palpitations
- Swelling of feet, ankles or hands

Gastrointestinal

- Loss of appetite
- Nausea or vomiting
- Frequent diarrhea
- Constipation
- Stomach pains or cramping
- Blood in stool

Genitourinary

- Burning or pain on urination
- Frequent urination
- Incontinence
- Blood in your urine
- Kidney stones

- Female-are you pregnant?

Musculoskeletal

- Muscle or joint pains
- Joint stiffness or swelling
- Back pain
- Weakness of muscle or joints
- Leg pains
- Redness or heat of any joint
- Cold feet
- Muscle pain or cramps
- Difficulty in walking
- Poor balance

Neurological

- Fainting
- Paralysis
- Numbness, burning or tingling sensations
- Loss of sensation
- Tremors
- Convulsions or seizures

Endocrine

- Heat intolerance
- Cold intolerance
- Excessive sweating
- Excessive thirst
- Excessive urination

Hematologic/Lymphatic

- Slow healing after cuts or surgery
- Bleed/bruise easily
- Enlarged glands

Psychiatric

- Nervousness
- Depression
- Insomnia

Allergies

- Sulfa
- Penicillin
- Pain medications, if so which one(s): _____

- Novocain
 - Aspirin
 - Tetanus antitoxin
 - Iodine
 - Neosporin
 - Metals
 - IV Dye
 - Tape
 - Latex
 - Bee Stings
- Other allergies: _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X _____
Signature of patient (or parent, if minor)

Date

X _____
Reviewing Physician

Date