



## MEDICAL HISTORY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

What is/are your main foot and/or ankle complaints?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### History of Present Illness:

When did your problem begin? \_\_\_\_\_

Did this problem begin after an accident, trauma, gradually or suddenly? \_\_\_\_\_

Check all the boxes that describe your pain or discomfort:  Other \_\_\_\_\_

Sharp  Dull  Aching  Tingling  Numbness  Burning  Constant  Occasional  Radiating  Localized

Does anything relieve the pain? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

How have you treated your problem so far? \_\_\_\_\_

### Review of Systems:

Please mark "Yes" or "No" to any of the following which apply to you.

- |                      |                      |  |                    |  |             |  |
|----------------------|----------------------|--|--------------------|--|-------------|--|
| 1. General:          | Weight loss:         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight gain:       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fever:      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Eyes:             | Glasses:             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Retinopathy:       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blindness:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Cardiovascular:   | Chest Pain:          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension:      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Clot: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                      | Poor Circulation:    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease:     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke:     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Respiratory:      | Shortness of Breath: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma:            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout:       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. GI:               | Stomach Ulcers:      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nausea:            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vomiting:   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Musculo/Skeletal: | Low Back Pain:       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis:         | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |  |
| 7. Skin:             | Psoriasis:           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash:              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Wounds:     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Neurological:     | Neuropathy:          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures:          | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |  |
| 9. Psychiatric:      | Chem. Dependency:    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression:        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anxiety:    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Endocrine:       | Diabetes:            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease:     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Hematological:   | Bleeding Disorder:   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer:            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia:     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                      | Sickle Cell Disease: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Trait: | <input type="checkbox"/> Yes <input type="checkbox"/> No |             |  |
| 12. Immunologic:     | HIV/AIDS:            | <input type="checkbox"/> Yes <input type="checkbox"/> No |                    |  |             |  |

Past Illnesses: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

**Social** Do you smoke?  Yes  No How many packs per day? \_\_\_\_\_  
 Have you ever smoked?  Yes  No How many years? \_\_\_\_\_ When did you quit? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No How many drinks per week? \_\_\_\_\_  
 Do you use street drugs?  Yes  No \_\_\_\_\_  
 Do you exercise?  Yes  No Describe weekly routine: \_\_\_\_\_  
 What is your occupation? \_\_\_\_\_

<b>Current Medications:</b>	<u>Name</u>	<u>Dose</u>	<u>Name</u>	<u>Dose</u>
(>8 see attached list)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

**Allergies:**  **No Known Drug Allergies**

Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfa	<input type="checkbox"/> Yes <input type="checkbox"/> No	Iodine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Novocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adhesive Tape	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No