



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? _____

Current Medications:	<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