

MEDICAL HISTORY FORM

Name: _____ Date: _____
 Birthdate: _____ Age: _____ Height: _____ Weight: _____
 Occupation/Employer _____
 Pharmacy _____ Pharmacy City _____

Primary Care Physician: _____ Date of Last Visit: _____
 Do you have Diabetes? Y N If so, do you wear Diabetic shoes? Y N
 Doctor Managing Diabetes: _____ Date of Last Visit: _____
 Cardiologist: _____ Date of Last Visit: _____

How did you learn about our office? Doctor Referral (name) _____
 Friend _____ Family _____
 Hospital (ER) Website Phone book Sign Previous Patient

Chief Complaint (Specific concern you would like addressed by your doctor today?) _____

When did your condition first begin? # ___ Days Ago # ___ Weeks # ___ Months # ___ Years Ago

Was it related to an injury? ___ No ___ Yes What Type? _____

Which activities make your condition worse? (Please check answers)

- Standing up Standing up at the end of the day Walking Running Athletics
- Uneven ground Certain Shoes Work Exercise Lifting Walking Barefoot Other: _____

Which of the following treatments have you tried? (Please circle answers)

- Anti-inflammatory medications Physical Therapy Stretching Shoe Modifications Padding Inserts
- Bracing Cortisone injections Surgery Aspirin Tylenol Pain Medications Soaks
- Ice Heat Rest Topical medications Other: _____

Does anything make your condition better? ___ No ___ Yes If so, Explain: _____

Mark the scale to indicate your average pain due to your foot and ankle condition.



 

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Imaginable

Has any other physician/person treated this condition? No Yes, whom & when: _____

Have you ever been to a podiatrist before? No Yes, who: _____

***** Don't Forget to Complete the Other Side *****

Past Medical History (Please check all that apply)

- Acid Reflux/GERD
- Anemia
- Arthritis
- Asthma
- Cancer/Type _____
- Chronic Back Pain
- Cirrhosis
- Congestive Heart Failure
- Depression
- Dementia
- Diabetes
- DVT (blood clot in leg)
- Emphysema/COPD
- Fibromyalgia
- Gout
- Heart Attack
- Heart Beat Irregular
- Heart Murmur
- Heart Disease
- Heart Pacemaker/AICD
- Hepatitis
- High Blood Pressure
- High Cholesterol
- Hypothyroid (low)
- HIV/AIDS
- Kidney Dialysis
- Kidney Disease
- Kidney Transplant
- Mental Illness
- Multiple Sclerosis (M.S.)
- Osteoporosis
- Parkinson's
- Peripheral Arterial Disease (PAD of legs)
- Peripheral Neuropathy
- Phlebitis
- Psoriasis
- Pulmonary Embolism (blood clot in lung)
- Raynaud's Disease
- Rheumatoid Arthritis
- Seizures
- Sickle Cell Anemia/Trait
- Sleep Apnea
- Stomach Ulcers
- Stroke
- Other _____

Medications

1. _____ 4. _____ 7. _____ 10. _____
 2. _____ 5. _____ 8. _____ 11. _____
 3. _____ 6. _____ 9. _____ 12. _____

Review of Systems (Please check all items that apply currently or recently)

1. Constitutional Symptoms	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Headache	<input type="checkbox"/> no symptoms
2. Musculoskeletal	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Stiffness	<input type="checkbox"/> no symptoms
3. Integumentary (Skin)	<input type="checkbox"/> Foot Ulceration	<input type="checkbox"/> Discoloration	<input type="checkbox"/> Rash	<input type="checkbox"/> no symptoms
4. Neurological	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Tremors	<input type="checkbox"/> Paralysis	<input type="checkbox"/> no symptoms
5. Cardiovascular	<input type="checkbox"/> Chest Pain/Pressure	<input type="checkbox"/> Calf Cramping	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> no symptoms
6. Respiratory (Lungs)	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> no symptoms
7. Endocrine	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> no symptoms
8. Hematologic/Lymphatic	<input type="checkbox"/> Foot or Ankle Swelling	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> no symptoms
9. Eyes	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> no symptoms
10. Ears, Nose, Throat, Mouth	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Sinus Problem	<input type="checkbox"/> no symptoms
11. Gastrointestinal	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> no symptoms
12. Genitourinary	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Urinary Frequency	<input type="checkbox"/> Urine Retention	<input type="checkbox"/> no symptoms
13. Psychiatric	<input type="checkbox"/> Addiction to Alcohol	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> no symptoms
14. Allergic/Immunologic	<input type="checkbox"/> Recent Asthma Attack	<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/> no symptoms

Allergies (Please check all that apply)

- No Known Drug Allergies
- Adhesive Tape
- Aspirin
- Codeine
- Demerol
- Iodine
- IV Dye
- Latex
- Local Anesthetics
- Penicillin
- Sulfa
- Other _____

Past Surgical History (Please check all that apply)

- Amputation
- Angioplasty (heart stent)
- Appendectomy (removal of appendix)
- Back surgery
- Bariatric surgery
- Carpal tunnel surgery
- Cholecystectomy (gall bladder)
- C-section
- Eye surgery
- Foot surgery (what?) _____
- Heart bypass
- Hernia repair
- Hip replacement
- Hysterectomy
- Knee replacement
- Knee scope
- Mastectomy
- Thyroid removal
- Tonsillectomy
- Vascular surgery
- Other _____
- Hospitalizations _____

Family History (Please check all that apply)

- Arthritis Cancer Diabetes Heart Disease Other _____

Social History

Do you smoke? Yes No How much? _____ How long? _____ Quit when? _____
 Do you drink alcohol? Yes No How much? _____ Do you vape or use nicotine products? Yes No
 Do you use illicit drugs? (cocaine, etc.) Yes No Do you use Marijuana or THC products? Yes No

Signature of Patient/Legal Guardian _____ Date _____

Physician Signature (Form completely reviewed) _____ Date _____