

Medical History

Patient Name: _____ Date: _____

Primary Physician's Name and Location: _____

Referring Physician's Name and Location: _____

1. Explain your foot/ankle problem Right Left _____

2. When did pain/discomfort begin (date): _____
Describe pain/discomfort: Burning Numbness Sharp Other _____

3. What makes the pain/discomfort better: _____

4. Have you had a physical trauma? No Yes _____

5. Have you had an accident? No Yes _____

6. Occupation: _____ Is your problem work related? Yes No

7. Past Medical History: Epilepsy High Blood Pressure Osteoarthritis
 Anemia Gout Kidney Disease Other Arthritis
 Bleeding Disorders Heart Problems Lung/Respiratory Disorders Rheumatic Fever
 Blood Clots Hepatitis Mitral Valve Prolapse Stroke
 Cancer _____ High Cholesterol Nerve Disorders Thyroid Disorders
 Diabetes HIV / AID Neurological Disorders Other: _____

8. List all medications/herbs/vitamins: NONE _____

9. Allergies: (Describe reaction) NONE
 Penicillin _____ Aspirin _____ Narcotic Agent / Codeine _____
 Anesthesia _____ Shellfish _____ Sulfa Drugs _____
 Nickel / Metal _____ Radiographic Contrast Dye _____
 Latex _____ Other _____

10. Are you currently pregnant? No Yes _____

11. Surgical History: Have you had surgery? Yes—if yes, describe below No
Surgery / Date: _____

12. Social History: (Only check what is pertinent to you)
 Tobacco Use Alcohol Use Exercise habits _____
 Caffeine Use Drug use (recreational, IV)

Patient Name: _____ Date: _____

13. Family History: (List relationship of family member(s) who have had these problems):

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> Rheumatology _____ | <input type="checkbox"/> Bleeding Disorders _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Other family History: _____ | | |

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced**.

Constitutional			
<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Sweats	<input type="checkbox"/> Weight Change
Head, Eyes, Ears, Nose and Throat			
<input type="checkbox"/> Wear Contact Lenses	<input type="checkbox"/> Dentures	<input type="checkbox"/> Wearing Eyeglasses	
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Cataract	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Sore Throat	
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Problems with eyesight	<input type="checkbox"/> Ringing in the Ears	
Cardiovascular			
<input type="checkbox"/> Chest Pain / Discomfort	<input type="checkbox"/> Cardiovascular Symptom	<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> Swelling lower extremity	<input type="checkbox"/> Leg Pain with Exercise	<input type="checkbox"/> Palpitations	
Hematologic/Lymphatic			
<input type="checkbox"/> Bleeding Problem	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Lymphoma	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Skin Lump - Location		
Respiratory			
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Previous Pulmonary Disease	
<input type="checkbox"/> Exposure to TB	<input type="checkbox"/> Cough	<input type="checkbox"/> Pulmonary Symptoms	
Gastrointestinal			
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Decrease in Appetite	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Constipation	
Endocrine			
<input type="checkbox"/> Often Thirsty	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Urinary Symptoms	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Prior Kidney Disease	
Musculoskeletal			
<input type="checkbox"/> Musculoskeletal symptoms	<input type="checkbox"/> Feeling weak	<input type="checkbox"/> Joint Pain, Arthralgia	
<input type="checkbox"/> Weakness of limbs	<input type="checkbox"/> Prior Fracture		
Nervous System			
<input type="checkbox"/> Ataxia	<input type="checkbox"/> Speech Difficulties	<input type="checkbox"/> Headache	
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Confusion/ Disorientation	<input type="checkbox"/> Fainting	
<input type="checkbox"/> Convulsions			
Skin			
<input type="checkbox"/> Rash	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Lesions	<input type="checkbox"/> Sun Sensitivity
<input type="checkbox"/> Color Change	<input type="checkbox"/> Slow Healing	<input type="checkbox"/> Infections	<input type="checkbox"/> Cracking
<input type="checkbox"/> Eczema (Pruritus)	<input type="checkbox"/> Growth	<input type="checkbox"/> Hair Loss	
Allergic, Immunologic History			
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Lupus	<input type="checkbox"/> Collagen Vascular
Psychiatric			
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tension	<input type="checkbox"/> Depression	