CAPITAL FOOT & ANKLE, PC
1150 NORTH 83RD STREET
LINCOLN, NEBRASKA 68505
(402) 483-4485

Medical History Form

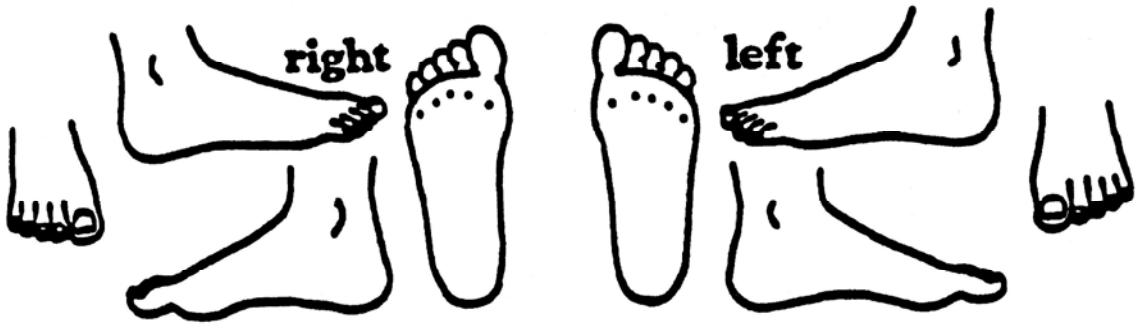
Today's Date: _____
MM/DD/YYYY

Name:		**Gender:** ☐ Female ☐ Male		**Date of Birth:**	MM/DD/YYYY
Primary Care Physician:			**Date of last physical exam:**		MM/DD/YYYY

CHIEF COMPLAINT:

What is your foot or ankle concern?		**Date symptoms started or injury occurred?**	MM/DD/YYYY

Please mark your area(s) of concern:



Where did the complaint/injury occur? ☐ Home ☐ Work ☐ School ☐ Sports ☐ Car accident ☐ Unknown

How did the complaint/injury occur? ☐ Sudden/Traumatic ☐ Gradual onset

What treatments have you had for this condition? ☐ None ☐ Oral Medications ☐ Injections ☐ Orthotics

☐ Surgery ☐ Physical Therapy ☐ Other:

What shoes do you wear? **Shoe size?**

Do you wear orthotics? ☐ Yes ☐ No **Do you wear a foot/ankle brace?** ☐ Yes ☐ No

ALLERGIES: Have you ever had an allergy to any of the following? ☐ No Known Allergies

- ☐ Sulfa: Describe reaction: _____
- ☐ Penicillin: Describe reaction: _____
- ☐ Codeine: Describe reaction: _____
- ☐ Hydrocodone: Describe reaction: _____
- ☐ Novocain: Describe reaction: _____
- ☐ Neosporin: Describe reaction: _____
- ☐ Latex: Describe reaction: _____
- ☐ Iodine: Describe reaction: _____
- ☐ Tape: Describe reaction: _____
- ☐ Jewelry (metals): Describe reaction: _____
- ☐ IV Dye: Describe reaction: _____
- ☐ Bee stings: Describe reaction: _____

Other allergies: _____

PREVIOUS SURGERIES: ☐ None

Type of Surgery	Dates	Hospital/Facility

Have you ever had General Anesthetics? ☐ Yes ☐ No

If yes, describe any problems: _____

Has any relative experienced problems with anesthetics? ☐ Yes ☐ No

If yes, what type of problems? _____

Do you require antibiotics before dental or surgical procedures due to a heart problem or joint replacement? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY: ☐ None

Has a relative (parents, siblings) ever been diagnosed with the following? Enter their relationship next to each condition.

☐ Heart Disease: _____

☐ Diabetes: _____

☐ Foot Problems: Type _____

☐ Blood Clot, Leg or Lung: _____

☐ Cancer: Type _____

☐ Bleeding Disorders: _____

☐ Other family medical history: _____

☐ Unknown

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Other: _____

Do you live ☐ Alone ☐ With Spouse/Parents ☐ With Roommate ☐ Assisted Living ☐ Nursing Home

Do you exercise? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never What kind of exercise? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____ per ☐ Day ☐ Week ☐ Month ☐ Year

Do you use tobacco? ☐ Yes ☐ No If yes, how much and for how long? _____ pack(s) per day for _____ years

Do you have a history of using street drugs? ☐ Yes ☐ No If yes, which drug(s)? _____

What is your work status? ☐ Student ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Disabled

Occupation: _____ What are your work activities? _____

MEDICAL HISTORY: ☐ No Medical Problems

Have you ever been diagnosed with any of the following? (Check all that apply)

☐ Ankle Sprains	☐ Stroke	☐ Lung Disease	☐ Crohn's Disease
☐ Foot/Ankle Fracture	☐ Seizures	☐ Asthma	☐ Ulcerative Colitis
☐ Bunions	☐ Charcot-Marie-Tooth Disease	☐ Bronchitis	☐ Kidney Failure
☐ Clubfoot	☐ Peripheral Neuropathy	☐ Emphysema	☐ Kidney Stones
☐ Foot/Ankle Tendon Rupture	☐ Diabetic Neuropathy	☐ COPD	☐ Diabetes
☐ Hammertoes	☐ Osteoporosis	☐ Tuberculosis	☐ Thyroid Disease
☐ Flat Feet	☐ Osteoarthritis	☐ Sleep Apnea	☐ Ovarian Cysts
☐ Heel Pain	☐ Rheumatoid Arthritis	☐ Peripheral Arterial Disease	☐ Endometriosis
☐ Foot/Ankle Infections	☐ Psoriatic Arthritis	☐ Varicose Veins	☐ Migraines
☐ Foot Ulcer	☐ Gout	☐ Blood Clot in Leg	☐ ADHD/ADD
☐ Corns/Calluses	☐ Charcot Arthropathy	☐ Blood Clot in Lung	☐ Anxiety
☐ Athlete's Foot	☐ Artificial Joints	☐ Bleeding Disorders	☐ Panic Attacks
☐ Plantar Warts	☐ Fibromyalgia	☐ Hemophilia	☐ Bipolar Disorder
☐ Ingrown Toenails	☐ Sciatica	☐ Sickle Cell Anemia/Trait	☐ Depression
☐ Fungal Toenails	☐ Spinal Stenosis	☐ Anemia	☐ Schizophrenia
☐ Leg Length Difference	☐ Degenerative Disc Disease	☐ HIV	☐ Alzheimer's
☐ Drop Foot	☐ High Blood Pressure	☐ Liver Disease	☐ Autism
☐ Cerebral Palsy	☐ Angioplasty/Heart Stent Surgery	☐ Hepatitis	☐ Psoriasis
☐ Multiple Sclerosis	☐ Heart Valve Abnormality	☐ Alcoholism	☐ Eczema
☐ Myasthenia Gravis	☐ Abnormal Heart Rhythm	☐ Cirrhosis	☐ Cancer
☐ Muscular Dystrophy	☐ Pacemaker/Defibrillator	☐ Acid Reflux/GERD	Where: _____
☐ Spinal Cord Injury	☐ Heart Attack	☐ Anorexia/Bulimia	☐ Other (please list):
☐ Parkinson's	☐ Heart Failure	☐ Stomach Ulcers	_____
☐ Polio	☐ Chest Pain/Angina	☐ Irritable Bowel Syndrome	_____

REVIEW OF SYSTEMS: Are you experiencing any of the following? (Please respond to all)

General
YES NO
- ☐ ☐ Recent weight increase
- ☐ ☐ Unexplained weight loss
- ☐ ☐ Marked fatigue
- ☐ ☐ Fever, chills, sweats
- ☐ ☐ Difficulty sleeping
- ☐ ☐ Bowel/bladder changes

Skin
YES NO
- ☐ ☐ Frequent rashes
- ☐ ☐ Frequent itching
- ☐ ☐ Open sores
- ☐ ☐ Dryness
- ☐ ☐ Changes in hair or nails
- ☐ ☐ Change in skin color
- ☐ ☐ Bruise easily
- ☐ ☐ Slow healing after cuts/surgery

Ears/Nose/Throat
YES NO
- ☐ ☐ Poor Hearing
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Nasal congestion
- ☐ ☐ Sinus problems (frequent)
- ☐ ☐ Hoarseness (persistent)

Mouth/Teeth
YES NO
- ☐ ☐ Dentures
- ☐ ☐ Strange taste
- ☐ ☐ Loss of taste
- ☐ ☐ Mouth sores

Eyes
YES NO
- ☐ ☐ Wear glasses/contacts
- ☐ ☐ Eye drainage

Cardiovascular
YES NO
- ☐ ☐ Chest pain
- ☐ ☐ Shortness of breath
- ☐ ☐ Abnormal heartbeat
- ☐ ☐ Swollen ankles

Lungs
YES NO
- ☐ ☐ Productive cough
- ☐ ☐ Difficulty breathing

Gastrointestinal
YES NO
- ☐ ☐ Loss of appetite
- ☐ ☐ Nausea or vomiting
- ☐ ☐ Frequent diarrhea
- ☐ ☐ Frequent constipation
- ☐ ☐ Stomach pains or cramping
- ☐ ☐ Blood in stool

Musculoskeletal
YES NO
- ☐ ☐ Joint pain/swelling
- ☐ ☐ Leg pain
- ☐ ☐ Muscle aches
- ☐ ☐ Difficulty walking
- ☐ ☐ Leg cramps

Genitourinary
YES NO
- ☐ ☐ Burning with urination
- ☐ ☐ Frequent urination
- ☐ ☐ Urinary incontinence

Females
YES NO
- ☐ ☐ Post-menopausal
- ☐ ☐ Absence
- ☐ ☐ Irregular
- ☐ ☐ Are you pregnant?

Last menstrual cycle: _____

Neurological
YES NO
- ☐ ☐ Fainting
- ☐ ☐ Poor balance
- ☐ ☐ Dizziness
- ☐ ☐ Headaches/migraines
- ☐ ☐ Numbness of extremities
- ☐ ☐ Seizures
- ☐ ☐ Tremors
- ☐ ☐ Weakness

Endocrine
YES NO
- ☐ ☐ Cold intolerance
- ☐ ☐ Heat intolerance
- ☐ ☐ Excessive sweating
- ☐ ☐ Excessive thirst
- ☐ ☐ Excessive urination

Psychiatric
YES NO
- ☐ ☐ Depression
- ☐ ☐ Nervousness

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, parent or guardian — Date

X _____ _____
Reviewing Physician — Date

In connection with the medical services that I am receiving from my Podiatrist, at Capital Foot Center, P.C., I consent that photographs or video may be taken of me or parts of my body. The photographs or video may be taken only with the consent of a Capital Foot Center podiatrist and under such conditions and at such times as may be approved by him or her. The photographs or video shall be used for medical records, and if in the judgment of the podiatrist, medical research, or education will benefit by their use, such photographs and information relating to my case may be published or otherwise used in professional journals or medical textbooks, or used for any other purpose which he/she may deem proper in the interest of medical education. It is understood that in any such publication or other usage of these photographs, I will not be identified by name.

X _____ _____
Signature of patient, parent or guardian — Date