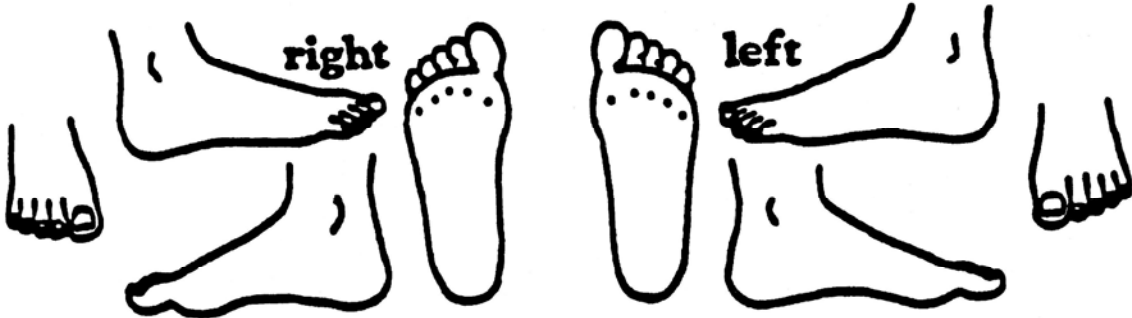


Medical History Form

Today's Date: _____
 MM/DD/YYYY

Name:		Gender: <input type="checkbox"/> Female <input type="checkbox"/> 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? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Sports <input type="checkbox"/> Car accident <input type="checkbox"/> Unknown				
How did the complaint/injury occur? <input type="checkbox"/> Sudden/Traumatic <input type="checkbox"/> Gradual onset				
What treatments have you had for this condition? <input type="checkbox"/> None <input type="checkbox"/> Oral Medications <input type="checkbox"/> Injections <input type="checkbox"/> Orthotics				
<input type="checkbox"/> Surgery <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Other: _____				
What shoes do you wear?			Shoe size?	
Do you wear orthotics? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you wear a foot/ankle brace? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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

- | | |
|--|---|
| <input type="checkbox"/> Sulfa: Describe reaction: _____ | <input type="checkbox"/> Latex: Describe reaction: _____ |
| <input type="checkbox"/> Penicillin: Describe reaction: _____ | <input type="checkbox"/> Iodine: Describe reaction: _____ |
| <input type="checkbox"/> Codeine: Describe reaction: _____ | <input type="checkbox"/> Tape: Describe reaction: _____ |
| <input type="checkbox"/> Hydrocodone: Describe reaction: _____ | <input type="checkbox"/> Jewelry (metals): Describe reaction: _____ |
| <input type="checkbox"/> Novocain: Describe reaction: _____ | <input type="checkbox"/> IV Dye: Describe reaction: _____ |
| <input type="checkbox"/> Neosporin: Describe reaction: _____ | <input type="checkbox"/> 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 HomeDo you exercise? Daily Weekly Occasionally Never What kind of exercise? _____Do you drink alcohol? Yes No If yes, how much? _____ per Day Week Month YearDo you use tobacco? Yes No If yes, how much and for how long? _____ pack(s) per day for _____ yearsDo 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)

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