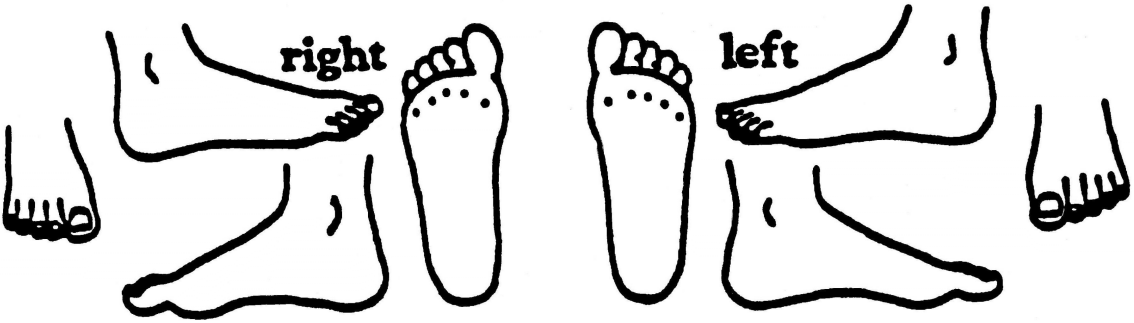


Medical History Form

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: Please list any allergies and reactions below: NONE

PREVIOUS SURGERIES: NONE

Type of Surgery	Dates

PREVIOUS HOSPITALIZATIONS: NONE

Type of Hospitalization	Dates

Patient Name: _____

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 Adopted

Has a relative (parents, siblings or children) ever been diagnosed with the following?

MOTHER: Diabetes Hypertension Heart Disease Stroke Mental Illness Cancer Unknown

FATHER: Diabetes Hypertension Heart Disease Stroke Mental Illness Cancer Unknown

MOTHER: Living Deceased FATHER: Living Deceased

SIBLINGS: Diabetes Hypertension Heart Disease Stroke Mental Illness Cancer Unknown

NUMBER OF BROTHERS: ____ Living Deceased NUMBER OF SISTERS: ____ Living Deceased

CHILDREN: Diabetes Hypertension Heart Disease Stroke Mental Illness Cancer Unknown

NUMBER OF SONS: ____ Living Deceased NUMBER OF DAUGHTERS: ____ Living Deceased

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 caffeine? Yes No Coffee Tea Soda If yes, how much? _____

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 Employed Unemployed Retired Disabled

MEDICAL HISTORY: No Medical Problems

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

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> IBS (Irritable Bowel Syndrome) | <input type="checkbox"/> Raynaud's Syndrome |
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Keloids | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> CHF (Congestive Heart Failure) | <input type="checkbox"/> Lupus | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> DVT (Deep Vein Thrombosis) | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Vasculitis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Bowel Disorder | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Breast Disease | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Peripheral Vascular Disease | Where: _____ |

Other (please list):

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

YES NO

- Recent weight increase
 Unexplained weight loss
 Change in appetite
 Fever
 Chills
 Night sweats
 Difficulty sleeping
 Bowel changes
 Bladder changes

Eyes

YES NO

- Wears glasses
 Wears contacts
 Eye drainage
 Eye dryness

Ears/Nose/Throat

YES NO

- Decreased hearing
 Difficulty swallowing
 Sore throat
 Swollen glands
 Nasal congestion
 Sinus problems (frequent)
 Hoarseness (persistent)

Mouth/Teeth

YES NO

- Dentures
 Strange taste
 Loss of taste
 Mouth sores

Respiratory

YES NO

- Productive cough
 Difficulty breathing

Endocrine

YES NO

- Cold intolerance
 Heat intolerance
 Excessive sweating
 Excessive thirst
 Frequent urination

Cardiovascular

YES NO

- Chest pain
 Shortness of breath
 Irregular heartbeat
 Swollen ankles
 Pain in legs when walking
 Pain in legs at rest

Gastrointestinal

YES NO

- Loss of appetite
 Nausea
 Vomiting
 Frequent diarrhea
 Chronic constipation
 Stomach pain
 Stomach cramping
 Blood in stool

Women Only

YES NO

- Hot flashes
 Irregular menses
 Absent menses
 Pregnancy

Last menstrual cycle: _____

Genitourinary

YES NO

- Painful urination
 Frequent urination
 Difficulty urinating

Musculoskeletal

YES NO

- Joint pain
 Joint swelling
 Leg pain
 Back pain
 Muscle aches
 Difficulty walking
 Weakness

Skin

YES NO

- Frequent rashes
 Frequent itching
 Open sores
 Skin dryness
 Hair changes
 Nail changes
 Skin color changes
 Bruising easily
 Slow healing after cuts or surgery
 Keloid formation

Neurologic

YES NO

- Fainting
 Poor balance
 Dizziness
 Headaches
 Tingling
 Numbness
 Seizures
 Tremor
 Weakness

Psychiatric

YES NO

- Depressed mood
 Nervousness

Current Medications List

Date of Visit: _____

Patient Name: _____ Date of Birth: _____

Pharmacy Name and Address: _____

Capital Foot & Ankle requires a current listing of all medications you are taking. This includes medications prescribed by other physicians, and any over-the-counter medications, including herbal supplements. Please complete this form.

- I am not currently taking any medications
- I have attached a current list of my medications

Name of Drug	Dosage/Strength	Frequency of Dose

Date Reviewed								
Doctor Initials								