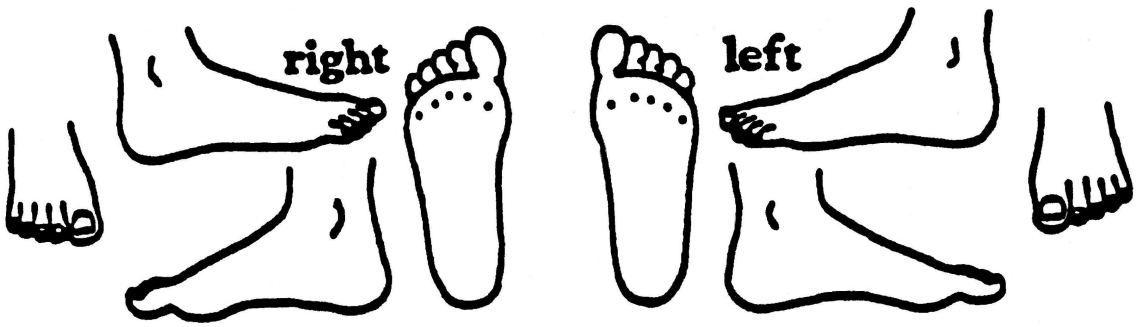
CAPITAL FOOT & ANKLE, PC
1150 NORTH 83RD STREET
LINCOLN, NEBRASKA 68505
(402) 483-4485

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: Please list any allergies and reactions below: ☐ **NONE**

PREVIOUS SURGERIES: ☐ **NONE**

Type of Surgery	Dates

PREVIOUS HOSPITALIZATIONS: ☐ **NONE**

Type of Hospitalization	Dates

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)

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