Medical History - Confidential Information

Lower Extremity Medical History

What is the chief complaint(s) which brings you to our office for medical treatment ?
(Include foot, ankle, leg, knee and hip complaints)

_____

_____

_____

_____

Former foot and ankle physician:
Name:_____

Last visit:_____

Any previous injuries or problems to the feet, ankles or legs?

_____

Symptoms

Which Side: ☐Right ☐Left ☐Both

Type of Pain: ☐Dull ☐Achy ☐Throbbing
☐Burning ☐Sharp ☐Shooting

Area of Pain:_____

Onset: ☐ Slow ☐ Sudden ☐ Traumatic

Duration: _____ Days Weeks Months Years

Has pain gotten: ☐Better ☐Worse ☐Stayed the Same

What aggravates condition? ☐ walking ☐ running
☐ standing ☐shoes

What have you tried to help the pain? ☐ Changing shoes
☐anti-inflammatories ☐ decrease activities
Other:_____

How long does pain last?_____

Have you ever had a similar pain? (describe, including treatments received)

_____

Exercise and Orthotics

In what athletic activities do you participate ?

_____

days per week exercising? _____

Do you wear store-bought arch supports? ☐ yes ☐ no
Do you wear custom orthotics? ☐ yes ☐ no
If yes, who made them: _____
How old are the orthotics: _____

Allergies and Drug Intolerance

☐ Adhesive/Tape ☐ Aspirin
☐ Codeine ☐ Iodine
☐ Local Anesthetics ☐ Penicillin
☐ Seafoods ☐ Sulfa
☐ No known drug allergies ☐ _____

Medications

List all medications you are taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

General

What is your weight:_____

What is your height: _____

What is your shoe size:_____

Mental / Emotional

☐ yes ☐ no Eating Disorder
☐ yes ☐ no Anxiety
☐ yes ☐ no Depression
☐ yes ☐ no Psychiatric
☐ yes ☐ no Alcoholism

Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illnesses <u>not</u> previously listed:

_____

_____

_____

_____

_____

Social History

Your occupation?

_____

Do you smoke? ☐ yes ☐ no

Are you a past smoker? ☐ yes ☐ no

How Much?____packs/ _____.
Years Smoked:_____

Drink Alcohol?: ☐ yes ☐ no
How Much:_____

Recreational Drugs? ☐ yes ☐ no
What:_____

Pregnant or possibly pregnant? ☐ yes ☐ no

General Medical History

Mark "yes" or "no" to indicate if you or a family member have any of the following:

Personal			Family Member
☐ yes	☐ no	Anemia	
☐ yes	☐ no	Arthritis: Type:_____	☐ yes
☐ yes	☐ no	Artificial Heart Valve or Joints	
☐ yes	☐ no	Asthma	☐ yes
☐ yes	☐ no	Back Problems	
☐ yes	☐ no	Bleed easily	☐ yes
☐ yes	☐ no	Cancer	☐ yes
☐ yes	☐ no	Chemical Dependency	☐ yes
☐ yes	☐ no	Chest Pain	☐ yes
☐ yes	☐ no	Circulatory Problems	☐ yes
☐ yes	☐ no	Diabetes	☐ yes
☐ yes	☐ no	Epilepsy	☐ yes
☐ yes	☐ no	Fibromyalgia	
☐ yes	☐ no	Gout	
☐ yes	☐ no	Heart Disease	☐ yes
☐ yes	☐ no	Hemophilia	☐ yes
☐ yes	☐ no	Hepatitis	
☐ yes	☐ no	High Blood Pressure	☐ yes
☐ yes	☐ no	HIV Positive	
☐ yes	☐ no	Kidney Problems	☐ yes
☐ yes	☐ no	Leg Cramps	
☐ yes	☐ no	Liver Disease	☐ yes
☐ yes	☐ no	Lung/Respiratory	☐ yes
☐ yes	☐ no	Menopause	
☐ yes	☐ no	Mental Illness	☐ yes
☐ yes	☐ no	Phlebitis / Clots	☐ yes
☐ yes	☐ no	Psoraisis	☐ yes
☐ yes	☐ no	Rheumatic Fever	
☐ yes	☐ no	Stroke	☐ yes
☐ yes	☐ no	Thyroid Problems	
☐ yes	☐ no	Tuberculosis	
☐ yes	☐ no	Ulcers—Stomach	
☐ yes	☐ no	Venereal Disease	
☐ yes	☐ no	Weight Change, Recent. _____lbs	

Patient/Guardian Signature: _____ **Date:** _____