SOMERSET FOOT AND ANKLE

PATIENT MEDICAL HISTORY FORM

DATE:_____

PATIENT NAME:_____ D.O.B:_____

PREFERRED NAME:_____ SHOE SIZE: _____ (MENS / WOMANS)

BRIEFLY DESCRIBE YOUR SYMPTOMS AND DURATION:_____

_____

_____

_____

LIST ANY PREVIOUS TREATMENTS FOR THE ABOVE PROBLEM:_____

_____

DRUG ALLERGIES: ☐ YES ☐ NO

PLEASE LIST ANYTHING THAT YOU ARE ALLERGIC TO. (I.E.: *ANTIBIOTICS/PENICILLIN, NOVOCAINE/ANESTHETICS, TAPE, IODINE, CORTISONE, LATEX, ETC.*): _____

_____

HAVE YOU HAD ANY ADVERSE REACTIONS TO INJECTIONS? : ☐ YES ☐ NO

CURRENT MEDICATIONS

PLEASE LIST ANY MEDICATIONS THAT YOU ARE NOW TAKING. INCLUDE NON-PRESCRIPTION MEDICATIONS & VITAMINS OR SUPPLEMENTS.

PLEASE INCLUDE NAME OF DRUG, DOSE(INCLUDE STRENGTH & NUMBER OF PILLS PER DAY) AND MEDICATION DURATION

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____
9._____ 10._____

SOCIAL HISTORY

SMOKING: ☐ YES ☐ NO PACKS PER DAY:_____ YEARS:_____ QUIT/WHEN? _____

ALCOHOL USE: ☐ YES ☐ NO DRINKS PER DAY:_____ YEARS:_____ QUIT/WHEN? _____

DRUG ABUSE: ☐ YES ☐ NO TYPE: PRESCRIPTION/ NON-PRESCRIPTION/ BOTH QUIT/WHEN? _____

CONTINUE ON BACK

SOMERSET FOOT AND ANKLE

PAST MEDICAL HISTORY

DO YOU NOW OR HAVE YOU EVER HAD:

☐ DIABETES(TYPE____)
☐ HIGH BLOOD PRESSUR
☐ HIGH CHOLESTEROL
☐ HYPOTHYROIDISM
☐ GOITER
☐ CANCER(TYPE_____)
☐ LEUKEMIA
☐ PSORIASIS
☐ ANGINA
☐ HEART PROBLEMS
☐ HEART MURMUR
☐ PNEUMONIA
☐ PULMONARY EMBOLISM
☐ ASTHMA
☐ EMPHYSEMA
☐ STROKE
☐ EPILEPSY(SEIZURES)
☐ CATARACTS
☐ KIDNEY DISEASE
☐ KIDNEY STONES
☐ CROHN'S DISEASE
☐ COLITIS
☐ ANEMIA
☐ JAUNDICE
☐ HEPATITIS(TYPE_____)
☐ STOMACH/PEPTIC ULCER
☐ RHEUMATIC FEVER
☐ TUBERCULOSIS
☐ HIV/AIDS
☐ CURRENTLY PREGNANT
☐ CURRENTLY BREAST FEEDING

PLEASE LIST ALL PREVIOUS SURGERIES: _____

_____

HAVE YOU EVER HAD VASCULAR SURGERY? ☐ YES ☐ NO (IF YES, PLEASE EXPLAIN):_____

FAMILY HISTORY

	LIVING?	*AGE/S*	*HEALTH*	*IF DECEASED; CAUSE*
FATHER	☐ YES ☐ NO			
MOTHER	☐ YES ☐ NO			
SIBLINGS	☐ YES ☐ NO			
CHILDREN	☐ YES ☐ NO			

SYSTEMS REVIEW

IN THE PAST MONTH, HAVE YOU HAD ANY OF THE FOLLOWING ISSUES?

GENERAL
☐ RECENT WEIGHT GAIN; HOW MUCH_____
☐ RECENT WEIGHT LOSS; HOW MUCH_____
☐ FATIGUE
☐ WEAKNESS
☐ FEVER
☐ NIGHT SWEATS

MUSCLE/JOINTS/BONES
☐ NUMBNESS
☐ JOINT PAIN
☐ MUSCLE WEAKNESS
☐ JOINT SWELLING(WHERE_____)

EARS
☐ LOSS OF HEARING

THROAT
☐ FREQUENT SORE THROATS
☐ HOARSENESS
☐ DIFFICULTY IN SWALLOWING
☐ PAIN IN JAW

PSYCHIATRIC ISSUES
☐ DEPRESSION
☐ ANXIETY

NERVOUS SYSTEM
☐ HEADACHES
☐ DIZZINESS
☐ FAINTING SPELLS
☐ NUMBNESS/TINGLING
☐ MEMORY LOSS

STOMACH/INTESTINES
☐ HEART BURN
☐ STOMACH PAIN
☐ VOMITTING
☐ INCREASING CONSTIPATION
☐ PERSISTENT DIARRHEA
☐ BLOOD IN STOOLS

HEART AND LUNGS
☐ CHEST PAINS
☐ PALPITATIONS
☐ SHORTHNESS OF BREATH
☐ FAINTING
☐ SWOLLEN LEGS/FEET
☐ COUGH

VASCULAR
☐ PAIN IN LEGS WHEN WALKING
☐ SWELLING IN LEGS/FEET
☐ PAIN IN LEGS AT NIGHT
☐ COLD FEET
☐ SORES ON FEET
☐ WOUNDS? (WHERE _____)
☐ VARICOSE VEINS
☐ HAIR LOSS
☐ COLOR CHANGES OF HANDS/FEET

EYES
☐ LOSS OF VISION
☐ DOUBLE OR BLURRED VISION

SKIN
☐ REDNESS
☐ RASH
☐ NODULES/BUMPS

KIDNEY/URINE/BLADDER
☐ FREQUENT/PAINFUL URINATION
☐ BLOOD IN URINE

OTHER MEDICAL CONDITIONS: _____

_____