ORTHOPEDIC/PODIATRY HISTORY

When did the problem start: _____

Is your present complaint due to an injury sustained at work? ☐Y ☐N

Is your present complaint due to a motor vehicle accident ☐Y ☐N

Describe the problem that brought you here_____

Which side of the body is injured: ☐ right ☐ left ☐ both

If unable to work, please give dates: from _____to_____

Type of pain: ☐ dull ☐ sharp ☐ burning ☐ constant ☐ radiating

Have you experienced (check all that apply) ☐ clicking ☐ swelling ☐ locking

☐ Buckling ☐ stiffness ☐ weakness ☐ difficulty using stairs

Any numbness or tingling? ☐Y ☐N

Does the pain wake you at night? ☐Y ☐N

If yes, what makes it better?_____

Does pain radiate to any other location?_____where?_____

Rate your pain from 1 to 10 (10 being the most severe) _____

Have you had a problem with this part of the body in the past? ☐Y ☐N

If yes, explain_____

Are you taking medication for this problem? _____

Describe any treatment thus far_____

Other physicians consulted for this problem_____

Weill Cornell Medicine NewYork-Presbyterian

MEDICAL HISTORY FORM **Date:**

Name:_____ **Birthdate**: _____ **Sex**: ☐M ☐F

Referring Physician: _____ __
Address & Telephone_____
_____

Primary Care: _____
Address & Telephone_____
_____

Other Physician: _____ _____ **Pharmacy Name & Number** _____

Reason for today's visit: _____

PAST MEDICAL HISTORY: **Have you ever had any of the following**:

Cancer ☐Y ☐N What type? _____ Are you on Blood thinners ☐Y ☐N Why?/Diagnosis_____

Hypertension	☐Y	☐N	Angina	☐Y	☐N	Carotid Stenosis	☐Y	☐N
Diabetes Type I	☐Y	☐N	Congestive Heart Failure	☐Y	☐N	Stroke When?)_____	☐Y	☐N
Diabetes Type II	☐Y	☐N	Atrial Fibrillation	☐Y	☐N	Amaurosis Fugax	☐Y	☐N
Hypercholesteremia	☐Y	☐N	Choric Renal Insufficiency	☐Y	☐N	Aneurysm (Aortic)	☐Y	☐N
Obesity	☐Y	☐N	End-Stage Renal Disease	☐Y	☐N	Aneurysm (Thoracic)	☐Y	☐N
Coronary Artery Disease	☐Y	☐N	Oxygen Dependent	☐Y	☐N	Iliac Artery Aneurysm	☐Y	☐N
Peripheral Vascular Disease	☐Y	☐N	Asthma	☐Y	☐N	Aneurysm (Popliteal)	☐Y	☐N
Claudication	☐Y	☐N	Lung Cancer	☐Y	☐N	Renal Artery Stenosis	☐Y	☐N
Peripheral Neuropathy	☐Y	☐N	Peptic Ulcer Disease	☐Y	☐N	Chronic Mesenteric Ischemia	☐Y	☐N
Anticoagulation	☐Y	☐N	GI Bleed	☐Y	☐N	Venous Insufficiency	☐Y	☐N
Lupus	☐Y	☐N	Prostate Cancer	☐Y	☐N	Deep Vein Thrombosis	☐Y	☐N
Vasculitis	☐Y	☐N	Colon Cancer	☐Y	☐N	Pulmonary Embolism	☐Y	☐N
						Varicose Veins	☐Y	☐N
						Superficial Thrombophlebitis	☐Y	☐N
						Ulcer (due to Venous Insuff)	☐Y	☐N
						Lymphedema	☐Y	☐N
						Lower Extremity Edema	☐Y	☐N

Angio Plasty/Stent	☐Y	☐N	When? _____
Heart Surgery	☐Y	☐N	When? _____
Stress Test	☐Y	☐N	When? _____
Difficulty walking	☐Y	☐N	If so, after how many blocks _____
Hepatitis	☐Y	☐N	If so, what type?_____
Joint replacement	☐Y	☐N	
HIV infection/AIDS	☐Y	☐N	

Other Medical problems: Please list all not included in above checklist

_____ _____ _____ _____

_____ _____ _____ _____

SURGICAL /HOSPITALIZATION HISTORY: Please list any surgery or hospitalization you have had and when they took place

_____ _____

_____ _____

MEDICATIONS/SUPPLEMENTS: Please list all medications you are taking. Include over the counter medications and any herbal, nutritional, vitamins supplement of steroid. (Please include dose and how often you take them.)

_____ _____

_____ _____

Are you allergic to any of the following:

Latex ☐Y ☐N Antibiotics ☐Y ☐N If so, Which Antibiotic? _____
Lidocaine ☐Y ☐N Contrast ☐Y ☐N
Adhesive tape ☐Y ☐N Other Medication(s): _____

SOCIAL HISTORY

Marital Status (Circle) : Married Single Divorced Widowed
Live with (Circle): Spouse Friend Family Alone
Currently Working: ☐Y ☐N Occupation: _____
Drink Alcohol ☐Y ☐N If yes, how many drinks per week? _____
Smoke tobacco ☐Y ☐N If yes, how many packs per day_____ for how many years_____ When did you quit? _____
Non-prescription Drugs ☐Y ☐N _____
Do you currently have a:
Visiting Nurse Agency providing care? If so, What is the phone number?
Home Health Aid Agency? If so, What is the phone number?
Home Attendant Agency? If so, What is the phone number?

FAMILY HISTORY

Diabetes	☐Y	☐N	**Father/Mother/Sibling**	Aneurysm	☐Y	☐N	**Father/Mother/Sibling**
Heart Attack	☐Y	☐N	**Father/Mother/Sibling**	High Blood Pressure	☐Y	☐N	**Father/Mother/Sibling**
Stroke	☐Y	☐N	**Father/Mother/Sibling**	Blood Clot	☐Y	☐N	**Father/Mother/Sibling**

CURRENT MEDICAL HISTORY: Do you have any of these symptoms?

General			**Respiratory**			**Neurological**		
Weight Change	☐Y	☐N	Shortness of Breath	☐Y	☐N	Headaches/migraines	☐Y	☐N
Fatigue/energy loss	☐Y	☐N	Wheezing	☐Y	☐N	Dizziness	☐Y	☐N
Fevers	☐Y	☐N	Cough	☐Y	☐N	Fainting	☐Y	☐N
Heat or cold intolerance	☐Y	☐N	**Gastrointestinal**			Muscle weakness	☐Y	☐N
Night Sweats	☐Y	☐N	Abdominal Pain	☐Y	☐N	Numbness	☐Y	☐N
Changes in nails	☐Y	☐N	Heartburn or ulcers	☐Y	☐N	Tingling	☐Y	☐N
Genitourinary			Loss of appetite	☐Y	☐N			
Loss of bladder control	☐Y	☐N	Nausea or vomiting	☐Y	☐N	**Psychiatric**		
Painful urination	☐Y	☐N	Constipation	☐Y	☐N	Panic disorder	☐Y	☐N
Blood in urine	☐Y	☐N	Diarrhea	☐Y	☐N	Mood changes	☐Y	☐N
Menstrual problems	☐Y	☐N	Blood in stools	☐Y	☐	Depression	☐Y	☐N
Cardio/Vascular			Muscle pain	☐Y	☐N	**Hematological**		
Murmur	☐Y	☐N	Arthritis or joint pain	☐Y	☐N	Anemia	☐Y	☐N
Chest pain	☐Y	☐N	Back or neck pain	☐Y	☐N	Bleed or bruise easily	☐Y	☐N
Irregular heartbeat	☐Y	☐N	**Immune**			Blood clots	☐Y	☐N
Swelling in feet	☐Y	☐N	Frequent infections	☐Y	☐N			
			Swollen glands	☐Y	☐N			

Height _____ **Weight** _____

Patient Signature_____ **Reviewed by MD** _____ **Date** _____