Lansdowne Foot & Ankle Center

Patient Medical History Form

If you are unable to print and complete this form prior to the appointment, please arrive 20 minutes early.

Last Name:_____ First Name:_____ MI:_____

☐Male ☐Female ☐Undifferentiated Height: _____ Weight: _____ Shoe Size: _____

History of Present Illness:

1. What specific problem brings you to our office today? _____
2. Where is the pain/condition located? ☐left foot/ankle ☐right foot/ankle ☐both
3. How long ago did this problem first start? _____
4. How would you describe the nature of your pain? ☐Sharp ☐Dull ☐Aching ☐Burning ☐Radiating ☐Itching ☐Stabbing ☐Throbbing ☐Sore Other:_____
5. How would you rate your pain on a scale of 0 to 10? _____
6. What seems to make the pain/condition feel worse? ☐Walking ☐Standing ☐Resting ☐Dress Shoes ☐Flat Shoes ☐Any Closed Shoe ☐Daily Activities ☐Exercise
7. What makes the condition feel better? _____
8. What treatments have you tried for this condition? _____
9. Is the problem the result of an injury? ☐YES ☐NO If yes, is it work related? ☐YES ☐NO
10. Do you participate in competitive sports? ☐YES ☐NO

Allergies:
☐ None
☐ Adhesive Tape
☐ Iodine/Shellfish
☐ Penicillin
☐ Aspirin
☐ Local Anesthetics
☐ Sulfa
☐ Codeine
☐ Demerol
☐ Novocaine

Other: _____

Medications: (include all prescriptions, over-the-counter medications and vitamins)

Previous Surgeries: (please list & include dates)

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Patient Medical History Form

(continued)

	YES	NO
Anemia	☐	☐
Asthma	☐	☐
Chest Pain	☐	☐
Ear Problems	☐	☐
Gout	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Migraine	☐	☐
Radiation Treatment	☐	☐
Sinus Problems	☐	☐
Varicose Veins	☐	☐

	YES	NO
Angina	☐	☐
Back Problems	☐	☐
Chronic Diarrhea	☐	☐
Epilepsy	☐	☐
HIV/AIDS	☐	☐
Heartburn	☐	☐
Liver Disease	☐	☐
Neuropathy	☐	☐
Respiratory Disease	☐	☐
Special Diet	☐	☐
Venereal Disease	☐	☐

	YES	NO
Arthritis	☐	☐
Bleeding Disorders	☐	☐
Circulation Problems	☐	☐
Eye Problems	☐	☐
Headache	☐	☐
Hemophilia	☐	☐
Low Blood Pressure	☐	☐
Phlebitis	☐	☐
Rheumatic Fever	☐	☐
Stroke	☐	☐

	YES	NO
Artificial Joints	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Fainting or Dizzy Spells	☐	☐
Hepatitis	☐	☐
Mental Health Disorders	☐	☐
Pneumonia	☐	☐
Shortness of Breath	☐	☐
TB	☐	☐

Other:_____

Women Only

	YES	NO
Are You Pregnant	☐	☐
Breast Feeding	☐	☐
Regular Menstrual Cycle	☐	☐

Family History: (Please list all medical conditions that run in the family)

Social:

	YES	NO		
Do you smoke?	☐	☐	If YES, what type/ frequency?	
Do you drink alcohol?	☐	☐	If YES, how much?	
Do you use drugs	☐	☐	If YES, what type/ frequency?	

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Patient Medical History Form

(continued)

Review of Systems: Are you experiencing any of the following conditions?

Constitutional	YES	NO
Fever / Chills	☐	☐
Nausea / Vomiting	☐	☐
Weight Gain	☐	☐
Weight Loss	☐	☐

Eyes	YES	NO
Blurry Vision	☐	☐
Double Vision	☐	☐
Eyeglass Use	☐	☐
Recent Injury	☐	☐

Ears/Nose/Throat	YES	NO
Nosebleeds	☐	☐
Sinus Infections	☐	☐
Hearing Impairment	☐	☐
Difficulty Swallowing	☐	☐
Frequent Sore Throats	☐	☐

Respiratory	YES	NO
Difficulty Breathing	☐	☐
Lung Disease	☐	☐
Short of Breath	☐	☐

Cardiovascular	YES	NO
Arrhythmia	☐	☐
Chest Pain	☐	☐
Heart Disease	☐	☐
Heart Murmur	☐	☐
Leg Pain - Walking	☐	☐
Palpitations	☐	☐

Gastrointestinal	YES	NO
Abdominal Pain	☐	☐
GI or Rectal Bleeding	☐	☐
GI Upset	☐	☐

Musculoskeletal	YES	NO
Joint Pain	☐	☐
Joint Stiffness	☐	☐
Lower Back Pain	☐	☐
Swelling	☐	☐

Psychiatric	YES	NO
Anxiety	☐	☐
Depression	☐	☐
Nervousness	☐	☐

Skin	YES	NO
Edema or Swelling	☐	☐
Itching	☐	☐
Rashes	☐	☐

Neurological	YES	NO
Burning	☐	☐
Headaches	☐	☐
Numbness	☐	☐
Seizures	☐	☐
Tingling	☐	☐

Endocrine	YES	NO
Cold Intolerance	☐	☐
Excessive Thirst	☐	☐
Excessive Urination	☐	☐
Heat Intolerance	☐	☐
Hormonal Problem	☐	☐

Hematologic / Lymph	YES	NO
Blood Clots	☐	☐
Phlebitis	☐	☐

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____ _____

Print Name of Patient, Parent or Guardian Signature of Patient, Parent or Guardian Date

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Confidential Patient Information

How did you hear about us? ☐Physician:_____ ☐Family/Friend ☐Website/Online ☐Other:_____

Primary Care Physician Name: _____

Date Last Seen By Primary Care Physician (MEDICARE ONLY): _____

Does Your Insurance Policy Require a Referral? ☐YES ☐NO

Patient Information (please write legibly)

First Name:_____ Last Name:_____ MI:_____

Date of Birth: _____/_____/_____ Sex: ☐Female ☐Male ☐Undifferentiated

Race: ☐DECLINE ☐American Indian or Alaska Native ☐Asian ☐Black or African American

☐Native Hawaiian or Other Pacific Islander ☐White ☐Unknown

Ethnicity: ☐DECLINE ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Home Address: _____

City:_____ State:_____ Zip Code:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Employment Status: ☐Employed ☐Unemployed ☐Full-Time Student ☐Part-Time Student ☐Other ☐Retired ☐Child

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Preferred Phone Number: ☐Home ☐Work ☐Cell

Email:_____

Emergency Contact:_____ Phone Number:_____

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Confidential Patient Information

(Continued)

Insurance Information Please present your insurance card at the time of your visit

Name of Insurance Company:_____

Policy Number:_____ Group Number:_____

Secondary Insurance Company (if applicable):_____

Policy Number:_____ Group Number:_____

Policy Holder (if patient, write "self")

Patient's Relationship: ☐Spouse ☐Child ☐Other

First Name:_____ Last Name:_____ Date of Birth:_____/____/_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

Guarantor Information (if patient, write "self")

First Name:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Employment Status: ☐Employed ☐Unemployed ☐Full-Time Student ☐Part-Time Student ☐Other ☐Retired ☐Child

Phone Number:_____

Pharmacy Information

Preferred Pharmacy:_____ Location:_____