

MEDICAL HISTORY FORM

Name: _____ Date: _____
 Birthdate: _____ Age: _____ Height: _____ Weight: _____
 Occupation/Employer _____
 Pharmacy _____ Pharmacy City _____

Primary Care Physician: _____ Date of Last Visit: _____
 Do you have Diabetes? Y N If so, do you wear Diabetic shoes? Y N
 Doctor Managing Diabetes: _____ Date of Last Visit: _____
 Cardiologist: _____ Date of Last Visit: _____

How did you learn about our office? Doctor Referral (name) _____
 Friend _____ Family _____
 Hospital (ER) Website Phone book Sign Previous Patient

Chief Complaint (Specific concern you would like addressed by your doctor today?) _____

When did your condition first begin? # ___ Days Ago # ___ Weeks # ___ Months # ___ Years Ago

Was it related to an injury? ___ No ___ Yes What Type? _____

Which activities make your condition worse? (Please check answers)

- Standing up Standing up at the end of the day Walking Running Athletics
 Uneven ground Certain Shoes Work Exercise Lifting Walking Barefoot Other: _____

Which of the following treatments have you tried? (Please circle answers)

- Anti-inflammatory medications Physical Therapy Stretching Shoe Modifications Padding Inserts
 Bracing Cortisone injections Surgery Aspirin Tylenol Pain Medications Soaks
 Ice Heat Rest Topical medications Other: _____

Does anything make your condition better? ___ No ___ Yes If so, Explain: _____

Mark the scale to indicate your average pain due to your foot and ankle condition.

☺ _____ 0 1 2 3 4 5 6 7 8 9 10 _____ ☹
 No Pain Worst Pain Imaginable

Has any other physician/person treated this condition? No Yes, whom & when: _____

Have you ever been to a podiatrist before? No Yes, who: _____

***** Don't Forget to Complete the Other Side *****

Past Medical History (Please check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Beat Irregular | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Peripheral Arterial Disease (PAD of legs) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Cancer/Type _____ | <input type="checkbox"/> Heart Pacemaker/AICD | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pulmonary Embolism (blood clot in lung) |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroid (low) | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Dialysis | <input type="checkbox"/> Sickle Cell Anemia/Trait |
| <input type="checkbox"/> DVT (blood clot in leg) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis (M.S.) | <input type="checkbox"/> Other _____ |

Medications

- | | | | |
|----------|----------|----------|-----------|
| 1. _____ | 4. _____ | 7. _____ | 10. _____ |
| 2. _____ | 5. _____ | 8. _____ | 11. _____ |
| 3. _____ | 6. _____ | 9. _____ | 12. _____ |

Review of Systems (Please check all items that apply currently or recently)

1. Constitutional Symptoms	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Headache	<input type="checkbox"/> no symptoms
2. Musculoskeletal	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Stiffness	<input type="checkbox"/> no symptoms
3. Integumentary (Skin)	<input type="checkbox"/> Foot Ulceration	<input type="checkbox"/> Discoloration	<input type="checkbox"/> Rash	<input type="checkbox"/> no symptoms
4. Neurological	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Tremors	<input type="checkbox"/> Paralysis	<input type="checkbox"/> no symptoms
5. Cardiovascular	<input type="checkbox"/> Chest Pain/Pressure	<input type="checkbox"/> Calf Cramping	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> no symptoms
6. Respiratory (Lungs)	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> no symptoms
7. Endocrine	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> no symptoms
8. Hematologic/Lymphatic	<input type="checkbox"/> Foot or Ankle Swelling	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> no symptoms
9. Eyes	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> no symptoms
10. Ears, Nose, Throat, Mouth	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Sinus Problem	<input type="checkbox"/> no symptoms
11. Gastrointestinal	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> no symptoms
12. Genitourinary	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Urinary Frequency	<input type="checkbox"/> Urine Retention	<input type="checkbox"/> no symptoms
13. Psychiatric	<input type="checkbox"/> Addiction to Alcohol	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> no symptoms
14. Allergic/Immunologic	<input type="checkbox"/> Recent Asthma Attack	<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/> no symptoms

Allergies (Please check all that apply)

- No Known Drug Allergies
- Adhesive Tape
- Aspirin
- Codeine
- Demerol
- Iodine
- IV Dye
- Latex
- Local Anesthetics
- Penicillin
- Sulfa
- Other _____

Past Surgical History (Please check all that apply)

- Amputation
- Angioplasty (heart stent)
- Appendectomy (removal of appendix)
- Back surgery
- Bariatric surgery
- Carpal tunnel surgery
- Cholecystectomy (gall bladder)
- C-section
- Eye surgery
- Foot surgery (what?) _____
- Heart bypass
- Hernia repair
- Hip replacement
- Hysterectomy
- Knee replacement
- Knee scope
- Mastectomy
- Thyroid removal
- Tonsillectomy
- Vascular surgery
- Other _____
- Hospitalizations _____

Family History (Please check all that apply)

- Arthritis Cancer Diabetes Heart Disease Other _____

Social History

Do you smoke? Yes No How much? _____ How long? _____ Quit when? _____
Do you drink alcohol? Yes No How much? _____ Do you vape or use nicotine products? Yes No
Do you use illicit drugs? (cocaine, etc.) Yes No Do you use Marijuana or THC products? Yes No

Signature of Patient/Legal Guardian _____ Date _____

Physician Signature (Form completely reviewed) _____ Date _____

PATIENT INFORMATION FORM

Patient Name: _____ Date: _____
(First) (Middle) (Last)
 Date of Birth: _____ Sex: M F Marital Status: S M W D S.S.# _____
 Address: _____
(Street) (City) (State) (Zip + 4)
 Phone: _____ Cell: _____ E-Mail: _____
 Primary Care Physician: _____ Date of Last Visit: _____
 Spouses Name: _____ Date of Birth: _____ Employer: _____
 Emergency Contact: _____ Phone: _____

Required by Medicare Ethnicity: Not Hispanic or Latino Hispanic or Latino
 Race: White Black Asian American Indian or Alaska Native Hawaiian or Pacific Islander

Primary Insurance: _____ I.D. # _____
 Policy Holders Name: _____ Date of Birth: _____
 Policy Holders SS#: _____ Relationship to Patient: _____
Secondary Insurance: _____ I.D. # _____
 Policy Holders Name: _____ Date of Birth: _____
 Policy Holders SS#: _____ Relationship to Patient: _____
Is this Worker's Comp? Y N **Auto Accident?** Y N **Other Accident?** Y N

Complete this Section if Patient is a Minor

Responsible Party: _____ Relationship to Patient: _____
 Date of Birth: _____ SS#: _____
 Address: _____

I attest that the information provided on this form is complete and accurate to the best of my knowledge. I hereby authorize Professional Foot & Ankle Centers, P.C. to furnish any medical information necessary to process insurance claims for my treatment acquired in the course of the examination or hospitalization. I authorize payment of medical and/or surgical benefits to Professional Foot & Ankle Centers, P.C. I understand that the provider's charge may exceed the insurance allowed amount and payment. I will be responsible for any and all balances such as co-insurance, co-payments, and deductibles.

Signature of Patient/Legal Guardian _____
Date

Print Name