



Virginia Foot & Ankle Surgical Associates

Reconstructive, Revisional, & Trauma Surgery

MEDICAL HISTORY

Reason for Today's Visit

Patient's Name (Last, First, M.I.):

Date:

Please describe current problem:

Which lower extremity: Left Right

How long has this problem troubled you:

Have you undergone previous treatment for this problem: Yes No If yes, please describe:

Is your problem a result of injury: Yes No If yes, date of injury:

Did injury occur while at work: Yes No

Medications (prescription and nonprescription medications)

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Allergies

Please indicate: No known allergies Yes, please list below (medication, food, materials etc.)

Medical History (please check all that apply)

	Yes	No		Yes	No
Arthritis/Bone-Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Breathing/Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Gynecological Problems (Females)	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Head and Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack Date _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood or Blood Product Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Injury/Trauma	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis (circle days) M T W T F S S	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Wounds	<input type="checkbox"/>	<input type="checkbox"/>
Dropfoot	<input type="checkbox"/>	<input type="checkbox"/>	Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ear/Nose/Throat Problems	<input type="checkbox"/>	<input type="checkbox"/>	Neuromuscular Disease	<input type="checkbox"/>	<input type="checkbox"/>

Medical History (Please check all that apply)

	Yes	No		Yes	No
Numbness or Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Other Serious Illnesses	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease or Trait	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>	Stroke Date _____	<input type="checkbox"/>	<input type="checkbox"/>
Positive Culture for MRSA/VRE	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Problems/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Positive Test for the AIDS Virus	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus Immunization Date _____	<input type="checkbox"/>	<input type="checkbox"/>
Previous Diabetic Foot Wounds	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Problems (Males)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric/Emotional Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Problems	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>

Family History

Father: Living _____ Deceased _____ **Mother:** Living _____ Deceased _____ **Siblings:** indicate # of siblings _____

Does or did anyone in your immediate family have any of the previously mentioned medical problems: Yes No

If yes, please describe:

Surgical History

Previous foot or ankle surgery: Yes No If yes, please describe: Right Left

Previous surgery other than foot or ankle: Yes No If yes, please describe:

Have you ever had any anesthetic agents: Yes No If yes, please indicate: ___ General ___ Spinal ___ Epidural
___ Sedation ___ Local ___ Regional Please describe any complications:

Do you have any internal metal, vascular or other implants (pins, grafts, screws, plates, clips, joints, etc.): Yes No

If yes, please describe:

Personal History

Do you smoke: Yes No If yes, how much:

Do you drink alcohol: Yes No If yes, how often:

Are you pregnant or breast feeding (females): Yes No If no, are you trying to become pregnant: Yes No

Do you participate in physical fitness activities: Yes No If yes, please describe:

Are you: Right handed Left handed Both Weight: _____ Height: _____

Do you use: ___ Cane ___ Walker ___ Brace ___ Crutches ___ Wheelchair ___ Prosthesis

Shoe size: _____ Shoe width: _____ What type of shoes do you wear: _____

If there is additional information that you think the doctor should know, please describe below.