



**MEDICAL HISTORY**

Reason for Today's Visit					
Patient's Name (Last, First, M.I.):					Date:
Please describe current problem:					
Which lower extremity: <input type="checkbox"/> Left <input type="checkbox"/> Right		How long has this problem troubled you:			
Have you undergone previous treatment for this problem: <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please describe:					
Is your problem a result of injury: <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, date of injury:				Did injury occur while at work: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medications (prescription and nonprescription medications)					
Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency
Allergies					
Please indicate: <input type="checkbox"/> No known allergies <input type="checkbox"/> Yes, please list below    (medication, food, materials etc.)					
Medical History (please check all that apply)					
	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
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 Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis (Circle Days) M T W T F S S	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Wounds	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dropfoot	<input type="checkbox"/>	<input type="checkbox"/>	Neuromuscular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ear/Nose/Throat Problems	<input type="checkbox"/>	<input type="checkbox"/>			

**Medical History (Please check all that apply)**

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
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"/>
Positive Culture for MRSA/VRE	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Problems/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Positive Test for HIV	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus Immunization	Date: _____	<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.