Virginia Foot & Ankle Surgical Associates

Medicine • Trauma • Reconstructive 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	☐	☐	Eye Problems	☐	☐
Anemia	☐	☐	Gout	☐	☐
Asthma/Breathing/Lung Problems	☐	☐	Gynecological Problems (Females)	☐	☐
Back Problems	☐	☐	Head and Neck Problems	☐	☐
Bleeding Problems	☐	☐	Heart Attack Date _____	☐	☐
Blood or Blood Product Transfusion	☐	☐	Hepatitis/Jaundice/Liver Disease	☐	☐
Blood Clots	☐	☐	High Blood Pressure	☐	☐
Cancer	☐	☐	High Cholesterol	☐	☐
Chemotherapy	☐	☐	Injury/Trauma Kidney Problems	☐	☐
Chest Pain/Heart Problems	☐	☐	Kidney Dialysis (Circle Days) M T W T F S S	☐	☐
Circulatory Problems	☐	☐	Lower Extremity Wounds	☐	☐
Diabetes	☐	☐	Lyme Disease	☐	☐
Dropfoot	☐	☐	Neuromuscular Disease	☐	☐
Ear/Nose/Throat Problems	☐	☐			

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Medical History (Please check all that apply)

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

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.

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