

Area Wide Foot and Ankle Center

**Patient Health History**

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Family Doctor \_\_\_\_\_ Last visit \_\_\_\_\_ Other Specialist/Doctor who you see \_\_\_\_\_

Referred here by : Doctor \_\_\_\_\_ Friend \_\_\_\_\_ Other \_\_\_\_\_

**Allergies:** **None** **Tape-what type** \_\_\_\_\_ **Rubber/Latex** **Seasonal** \_\_\_\_\_ **Foods** \_\_\_\_\_

(Circle correct choice)

**Allergy to Medication** \_\_\_\_\_ **Reaction** \_\_\_\_\_

Name of Medications	Dose	Frequency	Why do you take this?	What Dr. prescribed this?

(Continue on the back if the list is longer than the space available.)

List Pharmacy that you use: \_\_\_\_\_

**Surgeries** - Indicate what type and year  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hospitalizations** - (Not for surgery) Indicate reason and year  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Continue on the back if the list is longer than the space available.)

**FOOT AND ANKLE**

Have you ever broken a bone in your foot or ankle? **NO** **YES**  
Which bone \_\_\_\_\_ When \_\_\_\_\_

Have you had a problem with this area since that time? **NO** **YES**  
What problem \_\_\_\_\_

What is your normal shoe size? \_\_\_\_\_

**Circle any of these that you have had:**

- Ankle Pain
- Athlete's Foot
- Bunions
- Corns
- Calluses
- Flat Feet
- Foot Cramps
- Heel Pain
- Ingrown Nails
- Plantar Warts
- Swollen Feet
- Tired Feet

Have you ever been to a podiatrist before? **NO** **YES** For what problem \_\_\_\_\_

What problem brings you to the Doctor today? \_\_\_\_\_

**Other General Important Health Questions:**

Do you smoke? **NO** **YES** Type (Circle any that apply) **Cigarettes** **Cigars** **Other**  
Amt. per day \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you drink alcohol? **NO** **YES** Type (Circle any that apply) **Hard Liquor** **Beer** **Wine**  
Amt. per Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ For how many years? \_\_\_\_\_

**PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD**

**EENT**

Nose Bleeds  
 Difficulty Swallowing  
 Difficulty Chewing  
 Visual Problems  
 Glaucoma  
 Cataracts  
 Glasses  
 Contact Lenses  
 Hearing Problems  
 Sore in mouth that  
 will not heal  
 Thyroid Problem  
 Other \_\_\_\_\_

**NEUROLOGICAL**

Numbness of the arms  
 or legs  
 Fainting  
 Dizziness  
 Seizures/Epilepsy  
 Stroke  
 Headaches  
 Migraine Headaches  
 Other \_\_\_\_\_

**HEMATOLOGICAL**

Anemia  
 Bleeding Disorder  
 Hemophilia  
 Sickle Cell Anemia  
 HIV Positive  
 Other \_\_\_\_\_

**CARDIOVASCULAR**

Chest Pain/Angina  
 Heart Attack  
 Heart Disease  
 High Cholesterol  
 High Blood Pressure  
 Abnormal EKG  
 Swelling of the feet  
 or ankles  
 Abnormal Heart  
 Rhythm  
 Rapid Heart Rate  
 Artificial Heart Valve  
 Pacemaker  
 Blood Clot in Leg  
 Other \_\_\_\_\_

**RESPIRATORY**

Asthma  
 Emphysema  
 Lung Disease  
 Abnormal Chest x-ray  
 Shortness of Breath  
 Use Oxygen at Home  
 Tuberculous  
 Blood Clot in Lung  
 Chronic Cough  
 Blood in Sputum  
 Other \_\_\_\_\_

**SKELETAL/MUSCULAR**

Rash  
 Gout  
 Arthritis  
 Sore Not Healing  
 Limited motion in joint  
 Back Problems  
 Other \_\_\_\_\_

**GASTROINTESTINAL**

Abdominal Pain  
 Ulcer in Stomach  
 Hiatal Hernia  
 Nausea or Vomiting  
 Constipation  
 Diarrhea  
 Change in Appetite  
 Unexplained  
 Weight Loss  
 Heart Burn  
 Gall Bladder Problem  
 Other \_\_\_\_\_

**GENITOURINARY**

Difficulty Urinating  
 Frequent Infections  
 Kidney Problems  
 Prostate Problems  
 On Dialysis – Type  
 (Hemo) (Peritoneal)  
 Abnormal Female  
 Bleeding  
 Other \_\_\_\_\_

**LIVER**

Hepatitis  
 Yellow Skin/Jaundice  
 Other \_\_\_\_\_

**MENTAL HEALTH**

Depression  
 How long \_\_\_\_\_  
 Medication \_\_\_\_\_  
 Anxiety  
 Panic Attack  
 Agoraphobia  
**Obsessive/Compulsive**  
 Disorder  
 Schizophrenia  
**Chemical -Dependency**  
 Other \_\_\_\_\_

**OTHER DIAGNOSIS  
 OR CONDITIONS**

**Diabetic NO YES**  
**Year Diagnosed** \_\_\_\_\_  
**Medications** \_\_\_\_\_

**Have you been exposed  
 to any infectious  
 diseases in the last  
 month?**

Name \_\_\_\_\_  
 \_\_\_\_\_  
 Cancer  
 Where? \_\_\_\_\_  
 When? \_\_\_\_\_

**Are there any other medical conditions the doctor should be aware of? Please mention here:**

\_\_\_\_\_

**Does any one of your blood relatives have or have had any of the following conditions? (Please circle)**

**Diabetes    Cancer    Gout    Heart Disease    High Blood Pressure    Tuberculosis**

I certify that the above information is true and current to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_