

# UNIVERSITY FOOT AND ANKLE SPECIALISTS, INC.

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## PATIENT MEDICAL HISTORY – PLEASE COMPLETE THE ENTIRE FORM

PATIENT NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

CONCERNS: \_\_\_\_\_ Primary Doctor & Phone # \_\_\_\_\_

**CIRCLE EACH ANSWER**

1. Are you having pain? Where? \_\_\_\_\_ YES NO
2. Type of PAIN: **CIRCLE** Sharp Dull Aching Burning Radiating Electrical Shooting Buzzing Numbness
3. Pain Scale: **CIRCLE** 1 2 3 4 5 6 7 8 9 10
4. Pain Duration: **CIRCLE** seconds minutes hours days constant
5. How did your foot/ankle problem start? \_\_\_\_\_
6. Is the pain **CIRCLE** new old getting better same getting worst
7. Anything makes your foot/ankle problem better/worst? \_\_\_\_\_
8. Do your ankles swell during the day? \_\_\_\_\_ YES NO
9. Have you lost or gained more than 10 lbs in the past year? \_\_\_\_\_ YES NO
10. Allergies to Medications? \_\_\_\_\_ YES NO
11. Current Medications and dosage: \_\_\_\_\_
12. **CIRCLE** any that you have or have had and year diagnosed:

Heart Failure/CHF	Pre-Diabetes (no meds)	Hypothyroid	Hemophilia/Bleeding
Heart Attack/MI	Diabetes Type 2 (adult)	Emphysema	Anemia
Angina/Chest Pain	Diabetes Type 1 (child)	COPD	Sickle Cell Disease
Cholesterol	Gastric Ulcer	Tuberculosis	Jaundice
Heart Disease	Foot Ulcer	Asthma	Epilepsy/Seizures
Heart Murmur	Glaucoma	Cancer/Tumor	Fainting/Dizzy Spells
Hypertension	Kidney Disease	Chemotherapy	Nervousness
Artificial Heart Valve	Liver Disease	Radiation Therapy	Drug Addiction
Mitral Valve Prolapse	Arthritis	Hepatitis B or C (Serum)	Psychiatric Treatment
Heart Pacemaker	Rheumatoid	Venereal Disease	
Stroke	Steroid/Cortisone use	AIDS	
Deep Vein Thrombosis	Artificial Hip / knee	HIV	

13. Other condition(s) not listed \_\_\_\_\_
14. All Previous Surgeries (& dates): \_\_\_\_\_
15. Hospitalized or Emergency Care before (& dates) \_\_\_\_\_
16. Do you drink alcohol? Amount & years? \_\_\_\_\_ YES NO
17. Do you smoke? Amount & years? \_\_\_\_\_ YES NO
18. Family (father/mother/bro/sis) passed away from \_\_\_\_\_ YES NO
19. Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_
- **FOR WOMEN** -----
20. Are you taking birth control pills? \_\_\_\_\_ YES NO
21. Are you pregnant? \_\_\_\_\_ YES NO
22. Are you nursing? \_\_\_\_\_ YES NO

I have answered the above information necessary to provide me with the best medical care in a safe, efficient manner. I have answered all questions truthfully and to the best of my knowledge:

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