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:

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

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 _____