

## Patient Medical History Form

### FOOT HEALTHCARE ASSOCIATES

DR. NEAL MOZEN \* DR. MODUPE ADERIBIGBE \* DR. GARY DOCKS  
DR. LAAL ZADA \* DR. STEPHANIE MARTIN \* DR BRYAN WEST

### PHYSICIAN-SURGEONS OF THE FOOT AND ANKLE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

#### **Family Physician**

Dr. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Hospital Affiliation: \_\_\_\_\_

#### **Any Specialty Physicians being seen:**

Name: \_\_\_\_\_ / Phone: \_\_\_\_\_ / Condition being Treated: \_\_\_\_\_

Name: \_\_\_\_\_ / Phone: \_\_\_\_\_ / Condition being Treated: \_\_\_\_\_

Name: \_\_\_\_\_ / Phone: \_\_\_\_\_ / Condition being Treated: \_\_\_\_\_

Please describe the condition(s) that brought you in today:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#1 concern \_\_\_\_\_ #2 concern \_\_\_\_\_ #3 concern \_\_\_\_\_

*Is the discomfort (Please circle one):*

*Burning    Throbbing    Sharp    Dull    Aching    Other (Describe) \_\_\_\_\_*

THE SEVERITY OF DISCOMFORT/PAIN OF YOUR MAIN PROBLEM (Please circle one):

Rating at its worst:



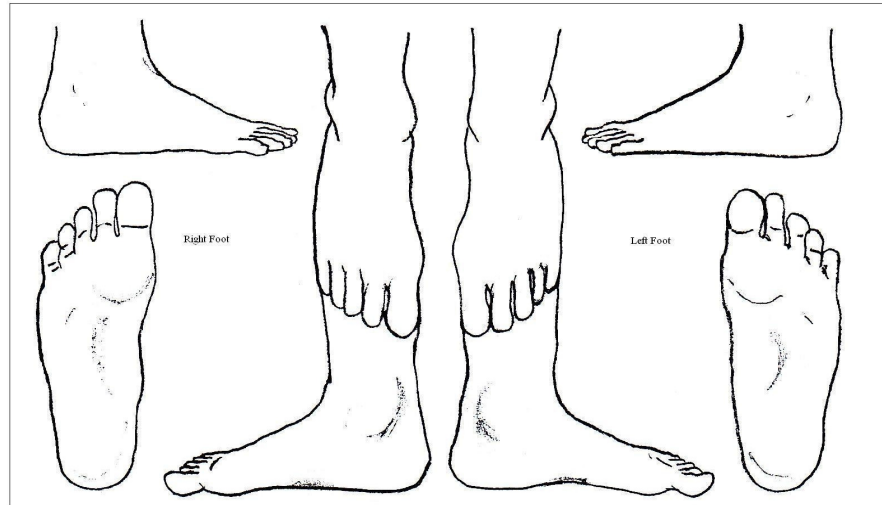
**mild    1    2    3    4    5    6    7    8    9    10    unbearable**

**Patient Name:**

**Date:**

**HISTORY OF PRESENT ILLNESS (HPI): PLEASE BRIEFLY ANSWER THE FOLLOWING QUESTIONS:**

Locate the areas of your concern:



When did your problem begin: \_\_\_\_\_ DAYS \_\_\_\_\_ MONTHS \_\_\_\_\_ YEARS

**ONSET:**  GRADUAL  SUDDEN EXPLAIN:

Is the problem getting worse, better or staying the same?  WORSE  BETTER  SAME

What seems to affect the problem? When is it better:

When is it worse:

Have you had this treated before?  NOT TREATED  ANOTHER DR. TREATED IT (who when, & how):

I TREATED IT AT HOME (how):

**Patient Name:**

**Date:**

Was this caused by an injury?     NO             YES

When:

Where:

How:

Who is the billing company:

Do you have any OTHER foot problems that need attention:     NO             YES

**If yes, please list those problems in order of importance on a separate piece of paper and describe them.**

PLEASE LIST ALL MEDICATIONS AND VITAMINS THAT YOU ARE TAKING:

(try to include the dosages and frequency that you are taking your medications or vitamins)     None

---

---

---

---

**ALLERGIES/INTOLERANCES (DESCRIBE REACTION):**

**NO KNOWN DRUG ALLERGIES**

Penicillin\_\_\_\_\_ Cortisone\_\_\_\_\_

Codeine\_\_\_\_\_ Shellfish\_\_\_\_\_

Iodine\_\_\_\_\_ Sulfa\_\_\_\_\_

Aspirin\_\_\_\_\_ Local Anesthesia\_\_\_\_\_

Tape\_\_\_\_\_ Latex\_\_\_\_\_

Other\_\_\_\_\_

**Patient name:**

**Date:**

**Please check** any condition(s) you are currently experiencing or have experienced in the past:

- |   |  |
|---|--|
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Difficulty healing                |
| <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Current pregnancy                 |
| <input type="checkbox"/> Heart Disease                  | <input type="checkbox"/> HIV/AIDS                          |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Sexually Transmitted Disease      |
| <input type="checkbox"/> Kidney Disease                 | <input type="checkbox"/> Cancer                            |
| <input type="checkbox"/> Liver Disease                  | <input type="checkbox"/> Seizures/Epilepsy                 |
| <input type="checkbox"/> Thyroid Disease                | <input type="checkbox"/> Asthma/Emphysema                  |
| <input type="checkbox"/> Stomach ulcers/GERD/IBS        | <input type="checkbox"/> Tuberculosis                      |
| <input type="checkbox"/> Stroke                         | <input type="checkbox"/> Neurological disorders/Disease    |
| <input type="checkbox"/> Gout                           | <input type="checkbox"/> Muscular disorders/Diseases       |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Previous problems with anesthesia |
| <input type="checkbox"/> Bleeding disorders/Blood clots | <input type="checkbox"/> Back Pain                         |
| <input type="checkbox"/> Anxiety                        | <input type="checkbox"/> Depression                        |

Please describe any other medical condition(s) not listed above:

---

---

---

---

Height\_\_\_\_\_ Weight\_\_\_\_\_ Shoe size\_\_\_\_\_

Are you Pregnant?  Yes  No (last menstrual period\_\_\_\_\_ )  N/A-Male

ARE YOU IN:  GOOD HEALTH  FAIR HEALTH  POOR HEALTH

**Patient Name:**

**Date:**

**PAST SURGICAL HISTORY/HISTORY OF HOSPITALIZATIONS**

Please describe any surgeries or hospitalizations that you have had in the past 10 years if any.  NONE

---

---

---

**Past History of any foot problems (not discussed above):**  NONE

---

---

---

**FAMILY HISTORY**

Do you have a family history of any conditions such as **Diabetes, Heart Disease, Blood Clots, Bleeding Problems, Strokes, Gout?**  NO.

**If Yes,** which condition and which family member? Also list any conditions not listed above:

---

---

---

**SOCIAL HISTORY**

What is your occupation? \_\_\_\_\_

Does your occupation/lifestyle require you to spend large amounts of time on your feet? If yes, please describe \_\_\_\_\_

Do you exercise?  NO  Yes (how often and how much) \_\_\_\_\_

Do you smoke?  NO  Yes (number of packs per day and how long) \_\_\_\_\_

Do you drink alcohol?  NO  Yes (how often and much) \_\_\_\_\_

Do you drink caffeinated beverages?  NO  Yes (how often and much) \_\_\_\_\_

DO YOU USE ILLICIT DRUGS SUCH AS MARIJUANA, COCAINE...  NO  YES

(EXPLAIN) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Name:**

**Date:**

## **REVIEW OF SYSTEMS**

**Please circle** any problems you are currently experiencing or have experienced in the past

### CONSTITUTIONAL

decreased appetite ▪ faintness ▪ dizziness ▪ headache ▪ fever ▪ difficulty breathing when lying flat  
feeling as if room is spinning ▪ weakness ▪ weight loss ▪ weight gain ▪ **NONE**

### CARDIOVASCULAR

chest or arm pain ▪ blood clots ▪ cramps in legs or feet when walking ▪ cramps in legs or feet when  
sleeping ▪ high blood pressure ▪ low blood pressure ▪ heart attack ▪ heart murmur ▪ heart  
palpitations ▪ stroke ▪ varicose veins ▪ mitral valve prolapsed ▪ **NONE**

### MUSCULOSKELETAL

joint ache or pain ▪ chronic neck pain ▪ chronic hip pain ▪ chronic low back pain ▪ chronic ankle  
pain ▪ stiffness ▪ morning stiffness ▪ weakness ▪ pain in the feet in the morning ▪ pain upon  
rising anytime ▪ swelling of joints ▪ limited motion in joints ▪ **NONE**

### INTEGUMENT

allergy to chemicals ▪ scarring ▪ dry skin ▪ itchy skin ▪ cracking skin ▪ thick or discolored  
toenails ▪ thick or discolored fingernails ▪ skin rash ▪ scarring after surgery or injury ▪ skin cancer  
pain associated with skin ▪ **NONE**

### NEUROLOGICAL

tingling ▪ pins and needles ▪ numbness ▪ increased sensitivity to touch ▪ burning ▪ decreased or  
lack of sensation to touch ▪ shooting pain ▪ decreased or lack of sensation to heat or cold ▪ radiating  
pain ▪ **NONE**

### ENDOCRINE

increase or decrease in thirst ▪ increase or decrease in urination ▪ diabetes mellitus ▪ thyroid  
problems ▪ post-menopause ▪ **NONE**

### HEMATOLOGICAL/LYMPHATIC

hemophilia ▪ anemia ▪ bruise easily ▪ blood transfusion reaction ▪ leukemia ▪ sickle cell disease  
or trait ▪ weakness ▪ yellow discoloration of the skin ▪ **NONE**

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

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