

**Patient Medical History Form**

**MOZEN FOOT HEALTHCARE ASSOCIATES  
PHYSICIANS-SURGEONS OF THE FOOT AND ANKLE**

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

<b>Family Physician</b> Dr. Name: _____ Phone: _____ Address: _____ Primary Hospital Affiliation: _____
<b>Any Specialty Physicians being seen:</b> 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:



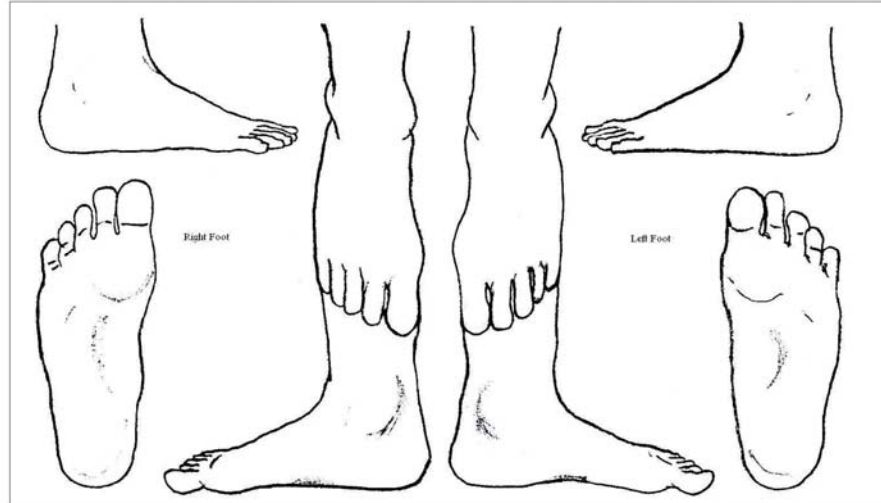
mild 1 2 3 4 5 6 7 8 9 10 unbearable

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

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

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

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

Blood Pressure: \_\_\_\_\_ Heart Rate/Pulse: \_\_\_\_\_ BMI: \_\_\_\_\_

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, if any.  NONE

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

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**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:

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**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) \_\_\_\_\_

Have you ever smoked?  NO  Yes

Do you currently smoke?  NO  Yes (Amount 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

CONSTITUTIONAL

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

CARDIOVASCULAR

chest or arm pain ▪ blood clots ▪ cramps in legs or feet when walking ▪ high blood pressure ▪ low  
blood pressure ▪ heart attack ▪ heart murmur ▪ heart palpitations ▪ stroke ▪ varicose veins ▪  
mitral valve prolapse ▪ **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 ▪ cramps in legs or feet when sleeping  
▪ **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 \_\_\_\_\_