

FOOT & ANKLE SURGICAL ASSOCIATES

MEDICAL HISTORY

Patient Name: _____ Age: _____ Today's Date: _____

Referring Physician: _____ Family Physician: _____

Date last seen by own physician: _____

SYMPTOM AREA (left/right, leg, foot, toes) _____

WHEN DID YOU FIRST NOTICE SYMPTOMS? (date if known) _____

DESCRIBE HOW YOUR SYMPTOM BEGAN _____

TREATMENT TO DATE (therapy, medications, etc.): _____

WHAT TREATMENT HAS HELPED? _____

HOW DO SYMPTOMS CURRENTLY EFFECT YOU? _____

CURRENT MEDICATIONS? _____

LIST ALL ALLERGIES/DRUG SENSITIVITIES: _____

LIST SURGERIES & APPROXIMATE DATES: _____

DO YOU HAVE / HAVE HAD ANY OF THE MEDICAL PROBLEMS BELOW (please circle):

<i>Heart problems</i>	<i>Breathing problems</i>	<i>Problem with surgery</i>	<i>Diabetes</i>
<i>Heart attack</i>	<i>Lung disease</i>	<i>Stroke</i>	<i>Thyroid/glandular problems</i>
<i>when _____</i>	<i>Bleeding problem</i>	<i>Paralysis/weakness</i>	<i>Cancer: when/where _____</i>
<i>Angina/chest pain</i>	<i>High blood pressure</i>	<i>Stomach problems</i>	<i>Arthritis: where _____</i>
<i>Kidney problems</i>	<i>Ulcers</i>	<i>Psychiatric/emotional</i>	<i>Osteoporosis</i>

Other _____

Height: _____ ft. _____ in. Any recent height loss? Yes/No _____ Shoe Size _____

Weight: _____ lbs. Any recent weight gain? _____ how much _____
loss? _____ how much _____

Women: Possibility of pregnancy? Yes/No _____

Occupation: _____ Marital status: S M D W

Tobacco use? _____ #Cans/Packs per day _____ • Alcohol use: _____ How much/often: _____

Street drug use? _____ Drug names? _____ Last use? _____

Form completed by: _____ Relationship to patient: _____