United Podiatry, PLLC

Medical History Form

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

Date of Birth:_____ **Height**:_____ **Weight**:_____ **Shoe Size**:_____

Address:_____

Home Phone:_____**Cell Phone:**_____

Primary Care Provider:_____**Last seen:** _____

How did you hear about us? _____

Chief Complaint

Why are you seeing the doctor today?_____

_____

Location, Most of my pain is in: (circle all that apply) **right left both foot ankle leg**

Nature of pain: (please circle) **aching throbbing sharp shooting burning electrical radiating**

Duration: How long have you had this problem? _____**days**_____**months**_____**years**

Is your activity level limited by pain? _____

Current pain level: _____/10

Onset: (circle one) **came on suddenly came on gradually on and off**

Course: (circle all that apply): **getting worse staying the same getting better comes and goes**

Aggravation: My pain is worse when (please circle all that apply) **at night with activity resting**

What makes it better:_____

Treatment: (list any treatment you have had for this problem, tests, x-rays, therapy, etc)_____

_____

Current problem is the result of: (if any)

_____ Car Accident _____ Work Accident _____Other Accident ____NOT Accident Related

_____	_____	_____
Date of Accident	**Location of Accident**	**Details of Accident or Injury**

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Past Medical History

List all current medical issues or problems _____

_____

_____

Allergies _____

Current medications

Medication	Dose	Times/Day	How Long

Prior Surgeries and/or Hospitalizations

Surgeries/Hospitalizations	Date	Reason

Have you ever had general anesthesia? **No** **Yes**

Have you ever had any problems with anesthesia?
(including general and/or dental injection/Novocaine) **No** **Yes, describe**_____

Doctor Signature of Review with Patient _____ Date_____

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Social History

Employment/Occupation_____

Tobacco/Alcohol/Drug Usage

Do you smoke currently? No Yes _____ packs/day for _____ years

Quit smoking? This year 1 year ago 5 years ago 10 or more years ago
(**Previously smoked**_____ **packs/day for** _____ **years**)

Alcohol? Daily Weekly Monthly Occasional

History of Substance Abuse_____

Flu Shot Status_____

Family History (do any of your family members have any history of the following medical conditions):

Diabetes	**no**	**yes**	Relationship to you: _____
High Blood Pressure	**no**	**yes**	Relationship to you: _____
Rheumatologic Disorder	**no**	**yes**	Relationship to you: _____
Heart Disease	**no**	**yes**	Relationship to you: _____
Stroke	**no**	**yes**	Relationship to you: _____
Bleeding Disorder	**no**	**yes**	Relationship to you: _____
Kidney Disease	**no**	**yes**	Relationship to you:_____
Mental Illness	**no**	**yes**	Relationship to you: _____
Cancer	**no**	**yes**	Relationship to you: _____

Review of Systems
Are you currently having or have you had any problems with: (Please circle all that apply)

General/Constitutional: nausea--vomiting--fever--chills--night sweats --weakness **NONE**
Eyes/Ears/Nose/Throat: glasses--cataracts--hard of hearing--sinuses--difficulty swallowing **NONE**
Lungs: shortness of breath--asthma--COPD--cough--tuberculosis--cannot sleep lying flat **NONE**
Heart: high blood pressure--chest pain--heart disease--heart attack--stents/bypass surgery **NONE**
Gastrointestinal: stomach ulcers--gastritis--reflux--colitis--diarrhea--constipation--colitis **NONE**
Genitourinary: bladder problems--prostate problems--urinary tract infections--incontinence **NONE**
Endocrine: diabetes--thyroid problems--liver disease--kidney disease--dialysis **NONE**
Hematological: bleeding problems--blood thinners--cancer--prior transfusions **NONE**
Vascular: swelling in feet/ankles/legs--circulation problems to feet/legs--varicose veins **NONE**
Neurological: numbness, tingling--burning--electrical pain to feet/ankles/legs--seizures **NONE**
Dermatological: infection--open wound--redness--ingrown toenail--painful toenails--bruising--bleeding warts--calluses--cracking heels--dry/peeling skin--athlete's foot--excessive sweating **NONE**
Musculoskeletal: heel or arch pain--ball of foot pain--top of foot pain--pain/fatigue of feet/ankles/legs weak or unstable ankles--achilles tendon pain--calf pain--arthritis **NONE**

Doctor Signature of Review with Patient _____ Date_____