UNIVERSITY FOOT & ANKLE INSTITUTE
MEDICAL HISTORY FORM

PATIENT NAME	DATE OF BIRTH

CHIEF COMPLAINT HISTORY

PLEASE DESCRIBE THE REASON FOR YOUR VISIT:

DATE OF INJURY/ONSET OR DURATION:

DESCRIBE YOUR SYMPTOMS: □ PAIN □ SWELLING □ BURNING □ TINGLING □ NUMBNESS □ PAIN AT REST □ PAIN WITH ACTIVITY □ OTHER SYMPTOMS:

WHAT TREATMENTS HAVE YOU TRIED? □ ORTHOTICS □ MEDICATIONS □ INJECTIONS □ PHYSICAL THERAPY □ SURGERY □ OTHER TREATMENTS:

HEALTH HISTORY

□ ARTHRITIS □ RA TYPE:	□ GOUT	□ DIABETES □TYPE 1 □TYPE 2	□ NEUROPATHY	□ LOW BACK PAIN
□ STROKE	□ CANCER TYPE:	□ CHEMICAL DEPENDENCY	□ ASTHMA	□ RESPIRATORY PROBLEMS
□ KIDNEY DYSFUNCTION	□ LIVER DISEASE	□ HEPATITIS	□ LOW BLOOD PRESSURE	□ HIGH BLOOD PRESSURE
□ CIRCULATION PROBLEMS	□ HEART PROBLEMS	□ ARTIFICIAL HEART VALVE	□ CHF	□ EPILEPSY
□ OBESITY	□ WEIGHT LOSS, UNEXPLAINED	□ AIDS/HIV	□ FAINTING	□ FIBROMYALGIA

MEDICATIONS, WITH DOSAGE (PLEASE INCLUDE OTC MEDS)

PHARMACY (NAME & LOCATION)	PHONE	FAX

ALLERGIES

□ PENICILLIN	□ LATEX	□ LOCAL ANESTHETIC	□ CODEINE
□ SULFA	□ IODINE □ SKIN □ IV	□ NOVOCAINE □ LIDOCAINE	□ ANTI-INFLAMMATORIES
□ SEAFOOD	□ ADHESIVE/TAPE	□ GENERAL ANESTHESIA	□ ASPIRIN
□ OTHER:			

SURGICAL HISTORY

SURGICAL PROCEDURE	YEAR	SURGEON or HOSPITAL	COMPLICATIONS?

----------BACK-----→

SOCIAL HISTORY

TYPES OF EXERCISE:

ARE YOU PREGNANT? □ YES □ NO	**SHOE SIZE**:	**HEIGHT:**	**WEIGHT:**

DO YOU DRINK ALCOHOL? □ NEVER □ QUIT □ OCCASIONALLY □ REGULARLY □ HEAVILY

DO YOU SMOKE? □ YES □ NO IF YES, PACKS PER DAY:

FAMILY HISTORY

MOTHER: □ ALIVE □ DECEASED ANY SIGNIFICANT MEDICAL HISTORY?

FATHER: □ ALIVE □ DECEASED ANY SIGNIFICANT MEDICAL HISTORY?

SIBLING: ANY SIGNIFICANT MEDICAL HISTORY?

REVIEW OF SYSTEMS

PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD IN THE PAST 3 MONTHS

GENERAL	□ FEVER	□ CHILLS	□ FATIGUE	□ WEIGHT GAIN/LOSS
HEAD	□ HEADACHES	□ VISUAL PROBLEMS	□ HEARING PROBLEMS	□ NECK PAIN
CARDIOVASCULAR	□ CHEST PAIN	□ PALPITATIONS	□ DIZZINESS UPON STANDING	□ LEG PAIN WHEN WALKING
HEMATOLOGY	□ ABNORMAL BLEEDING	□ BRUISING	□ BLOOD CLOTS	□ DELAYED HEALING
RESPIRATORY	□ PERSISTENT COUGH	□ WHEEZING	□ SHORTNESS OF BREATH	□ PAIN ON BREATHING
GASTROINTESTINAL	□ DIFFICULTY SWALLOWING	□ INDIGESTION OR HEARTBURN	□ ABDOMINAL PAIN	□ CHANGE IN BOWEL HABITS
URINARY	□ PAIN ON URINATION	□ FREQUENT URINATION	□ ICONTINENCE	□ BLEEDING ON URINATION
MUSCULOSKELETAL	□ JOINT PAIN OR SWELLING	□ JOINT STIFFNESS	□ CRAMPING	□ WEAKNESS
SKIN	□ SKIN RASH	□ ABNORMAL SKIN LESIONS	□ ITCHING	□ WOUNDS OR ULCERS
NEUROLOGICAL	□ NUMBNESS	□ SEIZURES	□ TREMORS	□ PARALYSIS
PSYCHIATRIC	□ DEPRESSION	□ ANXIETY	□ INSOMNIA	□ MEMORY LOSS
ENDOCRINE	□ HEAT/ COLD INTOLERANCE	□ HOT FLASHES	□ CHANGE IN HAIR/ SKIN TEXTURES	□ EXCESSIVE SWEATING

CONSENT FOR TREATMENT

THE INFORMATION PROVIDED HERE IS TRUE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE RELEASE OF ANY PREVIOUS MEDICAL RECORDS BY FAX, MAIL, OR PHONE TO EITHER A TREATING PHYSICIAN OR HOSPITAL. I ALSO GIVE PERMISSION TO THE PHYSICIAN OR HIS ASSISTANT(S) TO INITIATE THE DIAGNOSIS AND TREATMENT OF MY CONDITION WITH EXAMINATION, IMAGING STUDIES, AND/OR PHOTOGRAPHS AS DEEMED MEDICALLY RELEVANT AND NECESSARY.

SIGNATURE X_____ DATE: _____

IF MINOR, PARENT/GUARDIAN MUST SIGN

_____

PLEASE PRINT PARENT/GUARDIAN NAME

PLEASE STOP HERE

For office use only:

PHYSICIAN STATEMENT

I HAVE PERSONALLY REVIEWED THE ABOVE INFORMATION.
PHYSICIAN SIGNATURE: DATE: