

UNIVERSITY FOOT & ANKLE INSTITUTE

MEDICAL HISTORY FORM

PATIENT NAME	DATE OF BIRTH
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CHIEF COMPLAINT HISTORY

PLEASE DESCRIBE THE REASON FOR YOUR VISIT:
DATE OF INJURY/ONSET OR DURATION:
DESCRIBE YOUR SYMPTOMS: <input type="checkbox"/> PAIN <input type="checkbox"/> SWELLING <input type="checkbox"/> BURNING <input type="checkbox"/> TINGLING <input type="checkbox"/> NUMBNESS <input type="checkbox"/> PAIN AT REST <input type="checkbox"/> PAIN WITH ACTIVITY <input type="checkbox"/> OTHER SYMPTOMS:
WHAT TREATMENTS HAVE YOU TRIED? <input type="checkbox"/> ORTHOTICS <input type="checkbox"/> MEDICATIONS <input type="checkbox"/> INJECTIONS <input type="checkbox"/> PHYSICAL THERAPY <input type="checkbox"/> SURGERY <input type="checkbox"/> OTHER TREATMENTS:

HEALTH HISTORY

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

MEDICATIONS, WITH DOSAGE (PLEASE INCLUDE OTC MEDS)

PHARMACY (NAME & LOCATION)

PHONE

FAX

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ALLERGIES

<input type="checkbox"/> PENICILLIN	<input type="checkbox"/> LATEX	<input type="checkbox"/> LOCAL ANESTHETIC	<input type="checkbox"/> CODEINE
<input type="checkbox"/> SULFA	<input type="checkbox"/> IODINE <input type="checkbox"/> SKIN <input type="checkbox"/> IV	<input type="checkbox"/> NOVOCAINE <input type="checkbox"/> LIDOCAINE	<input type="checkbox"/> ANTI-INFLAMMATORIES
<input type="checkbox"/> SEAFOOD	<input type="checkbox"/> ADHESIVE/TAPE	<input type="checkbox"/> GENERAL ANESTHESIA	<input type="checkbox"/> ASPIRIN
<input type="checkbox"/> OTHER:			

SURGICAL HISTORY

SURGICAL PROCEDURE	YEAR	SURGEON or HOSPITAL	COMPLICATIONS?

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