Associated Podiatry Group of San Carlos

Foot & Ankle Specialists

Name:_____ Date: _____ DOB:_____ Age:_____

History & Medical Information

1. Explain your foot/ankle/toe problem_____ ☐ Left

_____ ☐ Right

2. When did the pain/ discomfort begin (date): _____ Duration:_____ (days/months)

Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____
Current Pain Level:_____/10 ("0" being least to "10")

3. What makes pain/discomfort better:_____

4. What makes pain/discomfort worse:_____

5. Has condition been treated? ☐ Yes ☐ No

6. Past Medical History:

☐ Anemia	☐ Gout	☐ Kidney Disease	☐ Other Arthritis
☐ Asthma	☐ Heart Disease	☐ Lung Disorders	☐ Prostate Disorders
☐ Bleeding Disorders	☐ Hepatitis	☐ Mitral Value Prolapse	☐ Rheumatic Fever
☐ Cancer	☐ High Cholesterol	☐ Nerve Disorders	☐ Thyroid Disorders
☐ Diabetes	☐ HIV/AIDS	☐ Neurologic	☐ Stroke
☐ Epilepsy	☐ High Blood Pressure	☐ Osteoarthritis	☐ Other_____
	Ave B/P reading:_____		

7. List all Medications/Herbs/Vitamins: ☐ None

_____

_____

8. Allergies: (Describe reaction that occurred) ☐ None

☐ Penicillin	☐ Anesthesia	☐ Aspirin
☐ Narcotic Agents/ Codeine	☐ Radiographic Contrast/ Dye	☐ Other _____
☐ Sulfa Drugs	☐ Shellfish	☐ Other_____

9. Surgical History:

Have you had surgery: ☐ Yes - if yes, describe below ☐ No

Surgery/Date:_____

_____

10. Social History: (Only check what is pertinent to you)

☐ Tobacco Use	☐ Alcohol Use	☐ Exercise Habits_____
☐ Caffeine Use	☐ Drug Use (recreational, IV)	☐ Occupation/Job_____

11a. Flu Vaccine current?: ☐ Yes or ☐ No 11b. Pneumonia Vaccine current?: ☐ Yes or ☐ No

12. Family History: (List relationship of family member(s) who have had these problems):

☐ Diabetes	☐ Heart Disease	☐ Bleeding Disorders	☐ Other_____
☐ High Blood Pressure	☐ Stroke	☐ Kidney Disease	_____
☐ Rheumatology	☐ Mental Illness	☐ Cancer	_____

13. Name of Primary Care Doctor or OB/GYN: _____ Date Last Seen: _____
Name of Specialist(s) which you are currently under their care:_____

_____

14. Pharmacy Name: _____ City: _____ Telephone: _____

Name:_____ Chart #_____

Review of Systems

Please check and of the following that you are **currently experiencing** or have **recently experienced**

1. Constitutional Symptoms:

☐ Fever ☐ Chills ☐ Sweats ☐ Weight loss ☐ **None**

2. Head, eyes, ears, nose, and throat: Do you...

Wear:

☐ Contacts ☐ Dentures ☐ Eyeglasses ☐ **None**

Have:

☐ Double vision ☐ Cataracts ☐ Ringing in ears ☐ **None**
☐ Difficulty swallowing ☐ Neck pain ☐ Sore throat
☐ Nosebleeds ☐ Dizziness

3. Cardiovascular (Heart & Blood Vessels):

☐ Chest pain, heart attack ☐ Heart murmur ☐ Swelling in legs/ ankles ☐ Cardiovascular surgery
☐ Congestive heart failure ☐ Palpitations ☐ Leg pain w/exercise ☐ **None**

4. Hematological/ Lymphatic (Blood) History of:

☐ Bleeding abnormalities ☐ Anemia ☐ Lump in groin or armpit ☐ **None**
☐ Swollen glands ☐ Lymphoma

5. Respiratory:

☐ Shortness of breath ☐ Emphysema ☐ Asthma ☐ Previous pulmonary disease
☐ Difficulty breathing ☐ Wheezing ☐ Pneumonia
☐ TB (tuberculosis) exposure or treatment ☐ Cough ☐ Bronchitis ☐ **None**

6. Gastrointestinal (Stomach and Intestinal Tract) History of:

☐ Nausea ☐ Blood in stool ☐ Diarrhea ☐ Constipation
☐ Decrease in appetite ☐ Abdominal pain ☐ Hepatitis ☐ **None**
☐ Vomiting

7. Endocrine:

☐ Often thirsty ☐ Often urinating ☐ Kidney disease ☐ Pancreatitis
☐ Diabetes mellitus ☐ Prostate problems ☐ Thyroid disorder ☐ **None**

8. Musculoskeletal (Bones & Joints):

☐ Tendonitis ☐ Bursitis ☐ Broken bones ☐ Arthralgia
☐ Weakness of limbs ☐ Feeling weak ☐ Inflammatory condition, Joint pain ☐ **None**

9. Nervous System History of:

☐ Migraines ☐ Aphasia(loss of speech) ☐ Strokes ☐ Nervous disorders
☐ Ataxia(loss of balance) ☐ Speech difficulties ☐ Confusion/ disorientation ☐ **None**
☐ Neuropathy(loss sensation) ☐ Seizures ☐ Fainting

10. Integumentary (skin):

☐ Rash ☐ Skin ulcers ☐ Lesions ☐ Sensitivity to the sun
☐ Change in skin color ☐ Growth on the skin ☐ Recurrent infections ☐ Cracking of the skin
☐ Eczema ☐ Keloid ☐ Hair loss ☐ **None**

11. Allergic, Immunologic History of:

☐ Dermatitis ☐ Any sensitivities ☐ Lupus ☐ Rheumatoid arthritis
☐ Other autoimmune disease (please list) _____ ☐ **None**

12. Psychiatric History of:

☐ Nervousness ☐ Tension ☐ Depression ☐ **None**

13. Have you had any history of falls in the last year? ☐ Yes ☐ No
Have any of these falls resulted in an injury? ☐ Yes ☐ No

Height: _____feet _____inches Weight: _____ pounds Shoe Size:_____ Width:_____