

AFFILIATED FOOT & ANKLE
Medical Health History Form

**PLEASE COMPLETE ALL PARTS OF THIS FORM, IT IS IMPORTANT TO
 PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL QUESTIONS**

Name: _____ Age: _____ Gender: Male / Female
 Date of Birth: _____ Height: _____ Weight: _____ Shoe size: _____
 Race: _____ Ethnicity: Hispanic / Non-Hispanic
 Preferred Language: English / Other _____
 What type of shoes do you typically wear? _____

What is the reason for your visit today? _____
 Where on your foot/ankle is your problem? _____
 How long has it been a problem (days, weeks, months, years)? _____
 Is it getting better, staying the same, or is it worse? _____
 How did it start, did you have an injury or any other inciting event/trauma? _____
 What makes it better? _____
 What makes it worse? _____
 What treatment have you or another doctor tried, if any? _____

 Was this a work related accident? _____ If so, date of accident? _____
 What activities do you participate in (sports, gardening, etc.)? _____
 Any other relevant information pertaining to your problem today? _____

Past Medical History: Please circle if you have, or have ever had, any of the following conditions

High blood pressure	Hormone gland problems	Cancer (type?)
Heart attack / MI	Hepatitis (what type?)	Anemia (type?)
Heart disease	Liver cirrhosis	Bleeding problems
Angina	Liver jaundice	High cholesterol
Heart failure	Liver cancer	Circulation problems
Bypass surgery	Gallbladder disease	Blood clots in legs / lungs
Mitral Valve Prolapse	Kidney infection	Arthritis (type?)
Irregular heart beat	Kidney stones	Gout
Murmur	Kidney	Psoriasis
Seizures / Epilepsy	failure/insufficiency	Skin disorder
Nervous system disorder	Urinary/Bladder infection	Immune disorder
Tuberculosis	Prostate disease	AIDS or HIV+
Asthma	Gynecological disorders	Joint pain / stiffness
Bronchitis	Stomach ulcers	Stroke
Pneumonia	Stomach bleeds	Psychiatric disorders
Emphysema	Hiatal hernia	Depression
Diabetes (# yrs diagnosed)	Gastro-esophageal reflux	Anxiety
Hyperthyroid (high)	Colon cancer	Problems with anesthesia
Hypothyroid (low)	Intestinal disease	

List any medical conditions not listed above: _____

Surgical History: Please list ALL surgeries and recent hospitalizations you have had & what year:

Allergies: Please list any allergies to **medications** or **food** and what **type of reaction** you had - (Penicillin? Sulfa? Latex? Metal? Shellfish? Iodine? Adhesive tape? Codeine?) _____

Medications: Please list ALL current medications you are taking, include dose and how often – (include all prescription and over-the-counter medications, vitamins, and herbal supplements):

Social History: How frequently do you **drink** beer, wine, and/or liquor? _____

Do you **smoke**?_____ How many **packs/cigars** a day?_____ For how many years?_____

Are you a current non-smoker, but used tobacco in the past?____How long ago did you quit?____

Do you take any illicit drugs? _____

Occupation:_____ At your job you mostly: Sit Stand Walk

Marital status:_____ **Women only**: Is there any chance you could be pregnant? _____

Family History: Please list your parents' health problems and if alive or deceased -

Mother:_____ Father:_____

List Any Family Health Problems? (Diabetes? Heart disease?)_____

“I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles.”

PLEASE SIGN FORM HERE: Patient: _____ Date:_____