

Health History

Last Name	First	MI	Age
-----------	-------	----	-----

Is this an Accident, Injury, or Workman's Comp: No Yes (If yes, ask for special history form)

Referred by: Doctor: _____ Insurance
 Friend: _____ Internet
 Yellow pages Acorn Other _____

What are your foot problems? (Please list e.g.: bunion, ingrown, toenail, ulcer, infection, toe pain, etc.)

1. _____
2. _____
3. _____

Please circle or answer all the symptoms that apply to your foot problems

(Please ask for more sheets if you have more than one problem.)

- Do you have pain? **Yes** **No**
- What words describe your pain? **sharp** **stabbing** **throbbing** **aching**
 tingling **shooting** **dull** **Other:** _____
- On a 10 point scale, please rate your pain. **Most** → **10 9 8 7 6 5 4 3 2 1** ← **Least**
- How long have you had this problem or pain? _____
- Is it getting **worse** or **better**?
- Is the problem **constant** or **"on and off"**?
- Have you tried any **self treatments or remedies** for this problem such as: **medications**
 massage **physical therapy** **exercise** **shoes** **pads** **ace bandage**
 braces?
- What **concerns you most** about the current problems? _____
- Does this problem **prevent** you from doing any activity? **Yes** **No** If yes, what activity? _____
- Have you had this problem before? **Yes** **No**
- Has anyone else **treated** you for this problem? **Yes** **No**. If yes, who was your previous doctor and what did he or she do for this problem? _____
- Can we ask your doctor for your old/previous records? **Yes** **No** **N/A**
- Was the current problem caused by an **injury** or **pre-existing condition**?
- Please list anything else you would like to let me know about the current problem. _____

Family Doctor and other Doctors currently taking care of you (please list all types of doctors):

Name: _____ Specialty or for what problem? _____ Location: (What city?) _____

1. _____
2. _____
3. _____
4. _____

Medical Problems (example: High blood pressure, Asthma, Hypothyroid, Diabetes, Emphysema, etc.):

Problem: _____ By what doctor: _____ How long: _____

1. _____
2. _____
3. _____
4. _____
5. _____

Medications (including prescriptions, birth control pills, herbs, and over-the-counter medications you take regularly):

	Problem:	By what doctor:	How long:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Prior surgeries (name procedure, year performed and complications such as bleeding, infection, scarring or nerve pain):

	Problem:	By what doctor:	How long:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Allergies (including anesthetics like Novocain, aspirin, iodine, tape, sulfa, or penicillin): None

	Allergy to:	What happens	When last taken
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Personal Information, Family, Social History:

Height: _____ Weight: _____ Shoe Size: _____ Are you Active Sedentary
Occupation: _____ Any sports? _____
Marital Status: Single Married Divorced Widowed
Have you ever smoked? No Yes How many packs per day? _____ For how many years? _____
Do you still smoke? No Yes If no, when did you quit? _____
Do you drink alcohol? No Socially Heavy History of alcoholism?
Do you use recreational drugs? No Yes

Review of Systems (Mark or list all problems, past or present, that you have, if none please indicate):

Skin None Nail problems Dryness Calluses Rashes Sores or ulcers on skin Blisters
 Itching Hair changes Change in skin color (blue, red, brown) Change in skin temperature

Skeletal None Deformities (location _____) Limitation in motion Joint pain Stiffness
 Weakness Paralysis Arthritis Gout Back problems Other: _____

Neurological None Numbness Tingling Loss of balance Difficulty walking Dizziness
 Burning Tremors Other: _____

Heart-Vascular None High blood pressure Heart Surgery Irregular heart beat/rhythm Coumadin Therapy
 Blood clot Chest pain Varicose veins Leg edema Calf or leg pain with exercise
 Stroke Heart Murmur Anemia Bleeding disorder Other: _____

Head None Glasses or contacts Loss of vision Double vision Sinus problems/Allergies Nosebleeds
 Seizures Hearing loss Dentures Other: _____

Endocrine None Diabetes Excessive urination Excessive thirst or hunger Fatigue Irritable
 Other: _____

General None Fever Chills Recent change in weight AIDS/HIV Other: _____

Psychological None Depression Anxiety Addictive tendencies Other: _____

Lungs None Cough Shortness of breath Wheezing COPD/Emphysema Asthma Other: _____

GI/GU None Nausea/Vomiting Painful urination Kidney problems Liver problems/hepatitis
 Menopause Currently pregnant Other: _____

Chronic Illness in relatives? None Diabetes Arthritis Cancer Bleeding problems
 Limb loss **Who?** _____

Anything else that I should know?

Reviewed by Dr. _____