

NORTHWEST FOOT AND ANKLE CENTER

MEDICAL HISTORY FORM

TODAY'S DATE: _____ NAME: _____
AGE: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____
FAMILY PHYSICIAN: _____ PHONE #: _____
REFERRING PHYSICIAN: _____ PHONE #: _____

REFERRAL SOURCE: PLEASE TELL US HOW YOU CHOSE US TO PROVIDE YOUR CARE:

- | | |
|--|---|
| <input type="checkbox"/> FRIEND OR FAMILY | <input type="checkbox"/> REFERRAL FROM ANOTHER DOCTOR |
| <input type="checkbox"/> YELLOW PAGES | <input type="checkbox"/> SIGN ON STREET OR BUILDING |
| <input type="checkbox"/> INSURANCE PROVIDER LIST | <input type="checkbox"/> WWW.NWFOOTANDANKLE.COM |
| <input type="checkbox"/> DEX ONLINE | <input type="checkbox"/> OTHER: _____ |

PODIATRIC MEDICAL INFORMATION:

DESCRIBE YOUR FOOT/ANKLE PROBLEM: _____

WHICH **FOOT** HURTS? RIGHT LEFT BOTH
WHICH **ANKLE** HURTS? RIGHT LEFT BOTH
HOW LONG HAS IT BEEN A PROBLEM? _____
RATE YOUR PAIN ON A SCALE FROM 0-10 (0=NO PAIN; 10=MOST SEVERE PAIN) _____
DOES YOUR PROBLEM AFFECT YOUR ACTIVITIES OF DAILY LIVING? HOW? _____

HAVE YOU HAD PREVIOUS TREATMENT FOR THE PROBLEM(S)? _____

HAVE YOU HAD **PAST** PROBLEMS WITH YOUR FOOT AND/OR ANKLE? _____

ARE YOU DIABETIC: _____

GENERAL MEDICAL: (CHECK IF YOU CURRENTLY HAVE OR HAVE HAD IN THE LAST YEAR)

- | | | |
|---|--|--|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> JOINT PAIN | <input type="checkbox"/> HEART PROBLEMS |
| <input type="checkbox"/> BLEED EASILY | <input type="checkbox"/> LOW BACK PAIN | <input type="checkbox"/> HEART BURN |
| <input type="checkbox"/> BRUISE EASILY | <input type="checkbox"/> NAUSEA | <input type="checkbox"/> URINARY PROBLEM |
| <input type="checkbox"/> CHILLS | <input type="checkbox"/> NON HEALING SORES | <input type="checkbox"/> VOMITING |
| <input type="checkbox"/> COUGH | <input type="checkbox"/> RASHES | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> SCARRING TENDENCY | _____ |
| <input type="checkbox"/> EMOTIONAL PROBLEMS | <input type="checkbox"/> SEIZURES | _____ |
| <input type="checkbox"/> FEVER | <input type="checkbox"/> SHORTNESS OF BREATH | _____ |
| <input type="checkbox"/> GOUT | <input type="checkbox"/> STOMACH ULCERS | _____ |

PLEASE ANSWER THE FOLLOWING QUESTIONS: (IF ANSWER IS NONE PLEASE INDICATE)

LIST ANY ILLNESSES: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____

LIST ANY DRUG ALLERGIES (IF NONE PLEASE WRITE NONE): _____

LIST ANY PREVIOUS SURGERIES AND DATES: _____

LIST FAMILY ILLNESSES: _____

OCCUPATION: _____

DO YOU:

CONSUME ALCOHOL? YES NO HOW MUCH: _____ HOW OFTEN: _____

USE TOBACCO? YES NO HOW MANY PACKS PER DAY: _____ HOW MANY YRS: _____

COMMENTS: _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY PHYSICIAN OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE

DATE

REVIEWED BY

DATE