Foot And Ankle Associates of North Texas

CURRENT MEDICAL HISTORY

Last Name: _____ Legal First Name: _____ MI: _____

DOB: _____ Age: _____ Gender: □ Male □ Female Weight: _____ Height: _____ Shoe Size: _____

□ PCP or □ Referring Physician: _____ Phone:_____ Date Last Seen: _____

Reason for Visit with Us: _____ Date Occurred: _____

Is your condition □ Work Related □ Automobile Accident □ Other Liability □ Not Related Work/Auto/Liability

Current Problem

Location: (where) □ Bilateral □ Bottom of □ In between □ Inside of □ Left □ Outside of □ Right □ Top of

Site: (what) □ Ankle □ Arch □ Ball of foot □ Calf □ Foot/feet □ Heel □ Hip □ Leg □ Toe(s) □ Other:_____

Quality: □ Aching □ Bruised □ Burning □ Cramping □ Deep □ Dull □ Improving □ Inflamed □ Itchy
□ Numb □ Pressure □ Sharp □ Swollen □ Tender □ Tight □ Tingling □ Other:_____

Pain scale: (Circle) 0 1 2 3 4 5 6 7 8 9 10 –worst
Severity: □ Mild □ Moderate □ Severe □ Unchanged

Duration: □ Today □ #_____Days □ #_____Week(s)
□ #_____Month(s) □ # _____ Year(s)

Timing: □ After exercise □ At night □ Constant
□ In AM □ Off and on □ Recurrent □ Other:_____

Cause/Context: □ Fell □ Foot type □ Increased activity
□ Injury □ Running □ Unknown □ Other:_____

Better with: □ Compression □ Elevation □ Heat □ Ice
□ Orthotics □ Shoes □ Medication □ Rest □ Other:_____

Worse with: □ Barefoot □ Increased activity □ In shoes
□ Pressure □ Running □ Walking □ Other:_____

Also have: □ Back pain □ Dementia □ Diabetes □ Fatigue □ Headaches □ Infection □ Muscle spasm
□ Numbness □ Osteoporosis □ Over weight □ Swelling □ OTC inserts □ Weakness □ Other: _____

Current Conditions—mark NONE for each condition that does not apply

Symptoms: □ **None** □ Chills □ Decline in health □ Fever
□ Night sweats □ Weight gain □ Weight loss

Eyes: □ **None** □ Blurry vision □ Cataracts
□ Eyeglass use □ Glaucoma □ Vision loss

Ears, Nose, Throat: □ **None** □ Dizziness □ Frequent sore throat
□ Hearing impairment □ Ringing in Ears □ Sinus Infection

Heart: □ **None** □ Chest pain □ Extremity(s) cold
□ Heart murmur □ Swelling in legs □ Ulcers on legs

Respiratory: □ **None** □ Asthma □ Cough □ Short of breath
□ Sleep apnea □ Snoring □ Wheezing

Intestinal: □ **None** □ Abdominal pain □ Constipation
□ Diarrhea □ Heartburn □ Nausea □ Vomiting

Urinary, Reproductive: □ **None** □ Blood Urine □ Pregnant
□ Urinary incontinence □ Sexually transmitted disease

Musculoskeletal: □ **None** □ Artificial joints □ Gout
□ Joint pain □ Muscle cramps □ Soft tissue pain □ Weakness

Skin: □ **None** □ Eczema □ Ingrown nail □ Lesion □ Nonhealing wound □ Nail appearance change □ Rash □ Ulcer □ Wart

Neurological: □ **None** □ Memory loss □ Migraines
□ Numbness □ Paralysis □ Seizures □ Strokes

Psychiatric: □ **None** □ Anxiety □ Claustrophobia
□ Depression □ Excessive stress □ Mood swings

Endocrine: □ **None** □ Diabetes □ Excessive thirst
□ Excessive urination □ Thyroid trouble

Hematological: □ **None** □ Anemia □ Bleeding easily
□ Blood transfusions □ Easy bruising

Immunologic: □ **None** □ Allergies □ HIV
□ Recurrent Infections □ Seasonal allergies

Pharmacy and Current Medications—mark CONSENT for RX history download

□ **Consent for medication history download from pharmacy (limited to certain plans)**

Pharmacy: _____

Street: _____

City/Zip: _____

Phone: _____

Medication	Dose	Frequency	Medication	Dose	Frequency

_____ _____ _____ _____

Print Name of Patient or Legal Authorized Representative | Signature | Relationship to Patient | Date