

Foot And Ankle Associates of North Texas

CURRENT MEDICAL HISTORY

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

DOB: _____ Age: _____ Gender: Female Male 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) Toenail Other: _____

Quality: Achy Brittle Bruised Burning Cramping Deep Dull Improving Inflamed Itching Numb
 Pressure Red Sharp Stabbing Swollen Tender Thick 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
 Ortho ≥ 1 yr Running Standing Unknown Other: _____

Better with: Compression Elevation Heat Ice
 Orthotics Shoe gear Medication Rest Other: _____

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

Also have: Arthritis Back pain Dementia Diabetes Fatigue Headaches Infection Muscle spasm
 Numbness Osteoporosis Overweight Swelling OTC inserts Weakness Wound 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

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

Heart: None Chest pain Extremity cold High Blood Pressure
 Heart murmur Swelling in legs Ulcers on legs

Intestinal: None Abdominal pain Constipation
 Diarrhea Heartburn Nausea Vomiting

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

Psychiatric: None Anxiety Claustrophobia
 Depression Excessive stress Mood swings

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

Neurological: None Memory loss Migraines
 Numbness Paralysis Seizures Strokes

Endocrine: None Diabetes Excessive urination
 Increased thirst Thyroid trouble

Hematological: None Anemia Bleeding easily
 Blood transfusions Easy bruising

Immunologic: None Allergies HIV
 Recurrent Infections Seasonal allergies

Urinary, Reproductive: None Blood Urine
 Pregnant Sexually Urinary incontinence

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: _____

| <u>Medication</u> | <u>Dose</u> | <u>Frequency</u> | <u>Medication</u> | <u>Dose</u> | <u>Frequency</u> |
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 Print Name of Patient or Legal Authorized Representative

 Signature

 Relationship to Patient

 Date