

## 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:  **None**  Work Related  Due to an Automobile Accident  Due to a liability claim

#### Current Problem

**Location:**  Bottom of  In between  Inside of foot  Left  Right  Top of  Other: \_\_\_\_\_  
**Site:**  Ankle  Arch  Ball of foot  Calf  Foot  Heel  Leg  Toe(s)  Other: \_\_\_\_\_

**Started:**  Today  # \_\_\_\_\_ Days  # \_\_\_\_\_ Weeks  # \_\_\_\_\_ Months  # \_\_\_\_\_ Years  
**How often:**  At night  Constant  In AM  Off and on  Rare  Recurrent  Other: \_\_\_\_\_

**Feels like:**  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  Improving  Resolved  Unbearable  Unchanged  
**Caused by:**  Barefoot  Fell  Increased activity  Injury  Running  Unknown  Other: \_\_\_\_\_

**Better with:**  Compression  Elevation  Heat  Ice  In shoes  Medication  Rest  Other: \_\_\_\_\_  
**Worse with:**  Increased activity  In shoes  No shoes  Pressure  Running  Walking  Other: \_\_\_\_\_

**Also have:**  Back pain  Dementia  Diabetes  Fatigue  Headaches  Infection  Muscle spasm  Numbness  Osteoporosis  Over weight  Swelling  Wear orthotics  Weakness  Other: \_\_\_\_\_

#### Current Conditions—mark NONE if the condition below does NOT apply to you

**Symptoms:**  None  Chills  Excessive Weight Gain/Loss  Fatigue  Fever  Loss of appetite  Night sweats  
**Eyes:**  None  Double vision  Dry eyes  Loss of vision  Pain  Redness  Other: \_\_\_\_\_

**Ears, Nose, Throat:**  None  Ear pain  Ear ringing  Dizziness  Hearing loss  Hoarseness  Loss of smell  
**Heart:**  None  Chest pain  Rapid heart rate  Shortness of breath  Swelling in legs or feet

**Respiratory:**  None  Productive cough  Shortness of breath  Snoring  Sleep apnea  Wheezing  Other: \_\_\_\_\_  
**Intestinal:**  None  Abdominal Pain  Bloating/Gas  Constipation  Diarrhea  Nausea  Vomiting

**Urinary, Reproductive:**  None  Blood Urine  Pregnant  Urinary incontinence  Sexually transmitted disease  
**Musculoskeletal:**  None  Artificial joints  Soft tissue pain  Weakness  Other: \_\_\_\_\_

**Skin:**  None  Ingrown nail  Lesion  Non-healing wound  Rash  Ulcer  Wart  Other: \_\_\_\_\_  
**Neurological:**  None  Memory loss  Migraines  Numbness  Paralysis  Seizures  Strokes

**Psychiatric:**  None  Anxiety  Claustrophobia  Depression  Hallucinations  Restlessness  
**Endocrine:**  None  Cold intolerance  Diabetes  Excessive thirst  Excessive urination  Heat intolerance

**Hematological:**  None  Anemia  Blood transfusions  Easy bruising  Prolonged bleeding  Other: \_\_\_\_\_  
**Immunologic:**  None  Allergies  HIV  Recurrent Infections  Other: \_\_\_\_\_

#### Pharmacy and Current Medications:

**Pharmacy:** \_\_\_\_\_ **Location:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

<u>Medication</u>	<u>Dosage</u>	<u>How Often</u>	<u>Medication</u>	<u>Dosage</u>	<u>How Often</u>

Print Name of Patient or Legal Authorized Representative

Signature

Relationship to Patient

Date