PATIENT MEDICAL HISTORY QUESTIONAIRE

Name _____

WHAT PROBLEMS ARE YOU HAVING WITH YOUR FOOT/ANKLE? X-ray # _____

_____

_____

Duration_____Related to a work or auto injury? ☐Yes ☐No

Shoe Size_____Regular shoe type_____Height_____Weight_____

Occupation_____Number of hours on feet for workday_____Surface standing on_____

Age_____Marital Status_____

ALLERGIES (Please check any of the following that you are allergic to.)

_____Latex _____Penicillin_____Novocain _____Codeine_____Adhesives

_____Iodine _____Aspirin _____Antihistamines _____Sulfa _____Other _____

_____Nylon _____Tetanus_____Anesthetics _____Darvon _____Other _____

_____Plastics _____Demerol_____Merthiolate _____Shellfish_____Other _____

Reaction_____

CURRENT MEDICATIONS (Including Inhalers, Patches, Vitamins, and Herbal Preparations)

DRUG NAME	AMOUNT OF DOSAGE	TIMES PER DAY	REASON

PAST SURGERIES/OPERATIONS ☐NONE

DATE	NAME OF OPERATION

SENSORY / INTEGUMENTARY

- Have you ever had any eye problems? ☐No ☐Yes Describe_____
- Do you have any problems with your hearing? ☐No ☐Yes Right / Left / Both
- Do you have any skin problems? ☐No ☐Yes Circle all that apply (eczema, acne, psoriasis, rash)

SOCIAL

- Do you drink alcoholic beverages? ☐No ☐Yes How many____How often_____
- Have you ever had a problem with alcohol abuse? ☐No ☐Yes Describe
- Are you currently a smoker? ☐No ☐Yes Packs per day_____Years_____
- Have you quit smoking in the past? When?_____ ☐No ☐Yes How many years did you smoke?_____

MUSCULOSKELETAL

- Do you have any physical disabilities? ☐No ☐Yes Describe_____
- Have you been diagnosed with arthritis? ☐No ☐Yes Describe_____
- Have you been diagnosed with muscle problems? ☐No ☐Yes Describe_____
- Do you have any back or neck problems? ☐No ☐Yes Describe_____

GASTROINTESTINAL

- Do you have any bowel problems? ☐No ☐Yes Describe_____
- Have you had a significant weight loss in the past four months without trying to diet? ☐No ☐Yes How much?_____
- Do you have nausea, vomiting or frequent heartburn after eating? (Circle all that apply) ☐No ☐Yes
- Have you ever been diagnosed with reflux or a hiatal hernia? ☐No ☐Yes
- Have you ever had mononucleosis, hepatitis or cirrhosis? ☐No ☐Yes Describe_____

CARDIO/NEURO/VASCULAR

- Have you ever had a heart attack? ☐No ☐Yes When_____
- Have you ever been diagnosed with angina or pain in the chest related to your heart? ☐No ☐Yes When_____
- Have you ever been treated for high blood pressure? ☐No ☐Yes
- Do you have a heart murmur or Mitral Valve Prolapse? ☐No ☐Yes
- Have you been diagnosed with an irregular or fast heart beat? ☐No ☐Yes
- Have you ever had fluid in the lungs related to heart failure? ☐No ☐Yes When_____
- Have you ever had phlebitis or blood clots? ☐No ☐Yes When_____
- Have you ever had a stroke/Parkinson's Disease or tremors? ☐No ☐Yes When_____
- Describe any left-over effects (i.e. paralysis)
- Do you have frequent headaches? ☐No ☐Yes Describe_____
- Have you ever had epilepsy or seizures? ☐No ☐Yes Date of last seizure_____

RESPIRATORY

- Do you have any difficulties with breathing or wheezing? ☐No ☐Yes Describe_____
- Have you ever been diagnosed with asthma? ☐No ☐Yes When_____
- Have you ever been diagnosed with emphysema? ☐No ☐Yes When_____
- Have you ever been diagnosed with hay fever, allergies, sinus problems? ☐No ☐Yes When did it start?_____
- Do you get short of breath walking up one flight of stairs? ☐No ☐Yes
- Do you currently have a cough/cold/sore throat or flu? ☐No ☐Yes Describe_____
- Have you ever had an abnormal chest X-ray? ☐No ☐Yes When/Results_____

ENDOCRINE/HEMATOLOGIC/GENITOURINARY

- Do you have diabetes? ☐No ☐Yes How long_____
- Have you ever been diagnosed with hypoglycemia? ☐No ☐Yes When_____
- Are you on a special diet now? ☐No ☐Yes Describe_____
- Have you ever had thyroid problems or a goiter? ☐No ☐Yes When/Describe _____
- Do you bleed or bruise easily? ☐No ☐Yes
- Have you had a blood transfusion in the last 3 months? ☐No ☐Yes
- Have you ever been diagnosed with anemia, Sickle Cell Anemia or any other blood or bleeding disorder? ☐No ☐Yes Describe_____
- Have you ever had any kidney or bladder problems? ☐No ☐Yes When/Describe _____
- Females: Could you be pregnant? ☐No ☐Yes

MISCELLANEOUS/OTHER

- Have you ever been diagnosed with Cancer? ☐No ☐Yes
- Have you had any illness/disease not mentioned above? ☐No ☐Yes When/Describe _____

Additional Comments:_____

_____

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