COMPREHENSIVE HEALTH REVIEW

Patient Name:________________________________ Date of Birth:_____________Today's Date:________________

HISTORY OF PRESENT ILLNESS/WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? ____
When did the problem begin? ____

Which foot/ankle is involved? ☐Right ☐Left ☐Both

First visit to a doctor for this problem? ☐Yes ☐No

Have you had a similar problem in the past? ☐Yes ☐No

How was the problem onset? ☐Sudden ☐Gradual
What improves the problem? ____
What aggravates the problem? ____

Is the problem painful? ☐Yes ☐No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: ☐Sharp ☐Dull ☐Aching ☐Throbbing ☐Cramping ☐Itching ☐Popping ☐Burning ☐Tingling ☐Clicking

☐Shooting ☐Stabbing ☐Other: ____

The problem is worst: ☐AM ☐PM ☐At Rest ☐With Activity
Describe previous treatments: ____

Is this from an injury? ☐Yes ☐No If so, is it work-related? ☐Yes ☐No
Primary Care Physician Name: ___________________________ Date Last Seen: __________ Phone #: ____________

PAST MEDICAL HISTORY

☐ Diabetes Type 1 2 Duration_____Years Last Blood Sugar: ____ HgA1C: ____

☐ Acid Reflux
☐ Anemia
☐ Anesthesia complications
☐ Arthritis
☐ Asthma
☐ Back problems/Sciatica
☐ Blood clot/DVT
☐ Cancer: ___________________
☐ Cellulitis/Skin Infections-MRSA
☐ Circulation Problem
☐ Parkinson's Disorder
☐ Previous Addiction To: _______
☐ Pulmonary Embolism
☐ Rashes/Skin Condition
☐ Raynaud's Disease/Phenomena

☐ Dementia/Alzheimer's
☐ Excessive/Easy Bleeding
☐ Fibromyalgia
☐ Foot/Leg Ulcer
☐ Gout
☐ Healing Problems/Keloids
☐ Heart disease/Heart Attack
☐ High Blood Pressure (Low BP?)
☐ High Cholesterol
☐ Hormone Therapy
☐ Seizure Disorder/Epilepsy
☐ Sickle Cell Disease/Trait
☐ Sleep Apnea
☐ Stomach Ulcers
☐ Stroke ☐Right ☐Left (Year:_____)

☐ Immune Disorder/HIV
☐ Kidney Disease (Dialysis)
☐ Liver Disease (Hepatitis)
☐ Leg Cramps/Leg Pain At Rest
☐ Lung Condition: ____________
☐ Mitral Valve Prolapse/Murmur
☐ Multiple Sclerosis
☐ Nervous Disorder/Depression
☐ Neuropathy
☐ Osteomyelitis/Bone Infection
☐ Thyroid Condition
☐ Varicose Veins
☐ Women-Are you pregnant or breast feeding?
☐ Other Problems Not Listed:
____

PAST SURGERIES

☐ Foot/Ankle Surgery: ____________________

☐ Joint Replacement: _______________________

☐ Open Heart/Bypass Surgery

☐ Hysterectomy /Tubal Ligation/C-Section

☐ Stent Placement: Heart Lung

☐ Cosmetic Surgery: _______________________

☐ Appendix Gallbladder Tonsils/Add

☐ Leg Bypass Open Fracture Repair

☐ Carotid Surgery Vein Surgery

☐ Hernia Repair Thyroid Back Surgery

☐ Other: _____________________________________

MEDICATIONS

Medication	Dosage	Medication	Dosage

ALLERGIES

☐ None

☐ Adhesives/Tape

☐ Aspirin

☐ Codeine

☐ Cortisone

☐ Latex

☐ Local Anesthetics

☐ Penicillin

☐ Seafood/Shellfish

☐ Sulfa Drugs

☐ Other ___________

____

____

SOCIAL HISTORY

Occupation: ____________________________

I Stand _______% of My Day

I Exercise Each Week: 0 Days/ 1-2 Days/ 3+ Days

List Sports/Activities:_____________________________

____

My foot/ankle problem limits my activities? ☐ Y ☐ N

I am: Single/ Married/ Divorced/ Separated/ Widowed

I live with: No One/ Spouse/ Children/ Parents/ Other

I drink alcoholic beverages: ☐ Y ☐ N

How much/often?_______________________________

I use or have used tobacco products Type: __________

Packs/Day: ____ Years: _______ When Stopped: ______

I use or have used drugs that are illegal ☐ Y ☐ N

VITALS

Age______Height______Weight________ Shoe Size_______ For Office Staff: BP______P_____BMI_____Temp______

The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care.

X____ ______________________________

Patient/Guardian Signature Date