HEALTH HISTORY

Patient Name____________________________ Age_______ Height_______ Weight______Shoe Size____

Nature of pain: ☐ Sharp ☐ Dull Ache ☐ Throbbing ☐ Burning ☐ Shocking

Onset: ☐ Gradual ☐ Sudden Location: ____

Primary Care Physician_______________________________________ Date last seen ____________________

Current foot or ankle problem____

When did this start?___________________ Due to an injury? Yes No Workers Comp? Yes No

Treatments tried____

Do you have a family history of:

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke
☐ Foot Deformity ☐ Other Foot Problems

Allergies: ________________________________
List all medications that you currently use:

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Do you have a history of:

Condition	Yes	No	Condition	Yes	No
Diabetes	☐ Yes	☐ No	Low back pain	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Heart disease/CAD	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Peripheral Vascular Disease	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Blood clots/Vasculitis/DVT	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No	Hepatitis A, B or C	☐ Yes	☐ No
Lung disease	☐ Yes	☐ No	Liver Disease (cirrhosis)	☐ Yes	☐ No
Hypothyroid disease	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Skin conditions	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Raynaud's	☐ Yes	☐ No
Anxiety/Depression	☐ Yes	☐ No	Cancer (specify type) __________________________		
			Fibromyalgia	☐ Yes	☐ No

Do you have any of these symptoms:

Symptom	Yes	No
Shortness of breath	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Cramps in feet or legs	☐ Yes	☐ No

List any surgeries you have had in the past with approximate dates:

____

Do you smoke? Y N Packs per day? _____ Do you drink alcohol? Y N Drinks per day? _______

Do you use recreational drugs? Y N If yes, please specify ______________________________________

Yes / No	Description	If yes, describe
Constitutional Symptoms		
❑ / ❑	Fever	
❑ / ❑	Chills	
❑ / ❑	Headache	
❑ / ❑	Weight Change	
Eyes		
❑ / ❑	Double Vision	
❑ / ❑	Pain	
❑ / ❑	Vision Change	
❑ / ❑	Cataracts/Glaucoma	
Allergic / Immunologic		
❑ / ❑	Hay Fever	
❑ / ❑	Drug Allergies	
Neurological		
❑ / ❑	Tremors	
❑ / ❑	Dizzy Spells	
❑ / ❑	Numbness/Tingling	
Endocrine		
❑ / ❑	Excessive Thirst	
❑ / ❑	Too Hot/Too Cold	
❑ / ❑	Tired/Sluggish	
Gastrointestinal		
❑ / ❑	Change in habits	
❑ / ❑	Abdominal Pain	
❑ / ❑	Nausea/Vomiting	
❑ / ❑	Indigestion/Heartburn	
Cardiovascular		
❑ / ❑	Chest Pain	
❑ / ❑	Lower Extremity Edema	
❑ / ❑	High Blood Pressure	

Yes / No	Description	If yes, describe
Skin		
❑ / ❑	Skin Rash	
❑ / ❑	Persistent Itch	
❑ / ❑	Skin cancer	
Musculoskeletal		
❑ / ❑	Joint Pain	
❑ / ❑	Neck Pain	
❑ / ❑	Back Pain	
Ear / Nose Throat / Mouth		
❑ / ❑	Ear Infection	
❑ / ❑	Sore Throat	
❑ / ❑	Sinus Problems	
Genitourinary		
❑ / ❑	Sexual Dysfunction	
❑ / ❑	Urination Problems	
❑ / ❑	Incontinence	
Respiratory		
❑ / ❑	Wheezing	
❑ / ❑	Frequent Cough	
❑ / ❑	Shortness of Breath	
Hematologic / Lymphatic		
❑ / ❑	Swollen Glands	
❑ / ❑	Bleeding/clotting	
Psychologic		
❑ / ❑	Are you generally satisfied with your life?	
❑ / ❑	Impaired by depression or anxiety?	
❑ / ❑	Self-harming behavior?	
Other:		

For Women: **Do you perform regular (monthly) self-breast exams? ❑ Yes ❑ No**

Breast Exam by Provider		
Mammogram		
PAP Smear/Pelvic Exam		
Last Menstrual Period		
Hormone Treatment		

For Men: **Do you perform regular (monthly) self-exam of testicles? ❑ Yes ❑ No**

PSA Blood Test		
Prostate/Testicle Exam		

What is your main reason for coming in today?

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Patient Signature______________________________ **Date**______________

Medical Provider Signature______________________________ **Date**______________