DESCHUTES
FOOT & ANKLE

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:

_____

Do you have a history of:

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:

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 _____