At Your Feet
Concierge Podiatry

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PATIENT MEDICAL HISTORY FORM

Name: ________________________________ Today's Date: ____________________ Age: ______

(*Doctor will fill in*) MRN: __________________

Date of Birth: ____________________ Height: __________ Weight: ___________ Shoe Size: _______

Pharmacy – Name: _______________________ Location: __________________________ Phone #: ____________

How did you hear about At Your Feet? ___________________________

CHIEF COMPLAINT

Why are you seeing the doctor?

____

____

What hurts? (circle answer) Left foot Right foot Left ankle Right ankle

How long has it been hurting? ________________________

Onset of the pain: (circle answer) After injury Sudden onset Gradual onset Off-and-on

Nature of the pain: (circle answer) Achy Throbbing Sharp/stabbing Shooting/radiating

Burning Numbness/Tingling

Course: (circle answer) Getting worse Getting better Staying the same Comes and goes

When is the pain worse? With activities With first steps after periods of rest In shoes At rest

Does anything make the pain better? ___________ **If "yes", what?** _______________________________

Treatments: (please list any treatments, tests, or x-rays you have had related to this problem)

____

____

PAST MEDICAL HISTORY

List all current medical issues/problems:

____

____

____

Current Medications:

Medication:	Dose:	Times/Day:

Allergies (Drugs, Metal, Latex, Food, Seasonal, Pet Dander, etc): ____

____

Surgical History: ____

Family History: Do any of your family members have a history of any of the follow?

Diagnosis	**Circle Answer**		**Relationship to you**
Diabetes	Yes	No	____________________
High Blood Pressure	Yes	No	____________________
Heart Disease	Yes	No	____________________
Stroke	Yes	No	____________________
Cancer	Yes	No	____________________
Rheumatological Disorder	Yes	No	____________________
Bleeding Disorder	Yes	No	____________________
Kidney Disease	Yes	No	____________________
Mental Illness	Yes	No	____________________

SOCIAL HISTORY

Marital Status: ___________________________

Are you pregnant, could be pregnant, or planning to get pregnant in the near future? _________

Are you on birth control and if so, which one? _______________

Occupation: ____ **Company:** _____________________________

Exercise: How often? ________ (times/week)
Type(s) of exercise ____

Tobacco Use: Yes / NoIf so, how much? ____ packs/day for ____ years

Alcohol Use: Yes / No If so, how much? ____ drinks/week of ____ beer ____ wine ____ liquor

Review of Systems
Are you current having or have you recently (**within the last 30 days**) had any problems with: (circle)

General/Constitutional: Nausea Vomiting Fevers Chills Night sweats Wt. loss/gain NONE

HEENT: Headache Visual changes Sinus pain Hard of hearing Difficulty swallowing NONE

Cardiovascular: Chest pain Shortness of breath Palpitations Edema NONE

Respiratory: Cough Sputum Shortness of breath Wheezing NONE

Gastrointestinal: Abdominal pain Difficulty swallowing Diarrhea Constipation NONE

Genitourinary: Painful urination Frequent urination Bloody urine Vaginal discharge NONE

Musculoskeletal: Pain Joint swelling Stiffness Functional deficit Arthritis NONE

Dermatological: Rash Skin lesion Open wound Mass/lump NONE

Neuro: Numbness/tingling Pins-and-needles Limb weakness Poor balance NONE

Psychiatric: Depression Anxiety Lack of energy NONE

Hematological: Easy bleeding Easy bruising NONE

Please use this space to explain in further detail if you circled any of the above:

____
____
____
____

Doctor signature/reviewed ____________________________________ Date _____________
Jennifer Nicole Falk, DPM