MEDICAL HISTORY QUESTIONNAIRE

Patient Name: ____ Date:________________

HISTORY OF PRESENT ILLNESS

What is the MAIN reason you are here today? ☐ Foot Right / Left ☐ Ankle Right / Left
(Please circle & check all that apply)

When did this begin? Give EXACT date if possible. ______________________________________

Pain Scale - On a scale of 1-10 where is your pain today? 1 2 3 4 5 6 7 8 9 10
(1 = little to no pain - 10 = worst pain of your life) (Please Circle)

Work Related Accident? Yes / No Auto Accident? Yes / No

Are you represented by an Attorney? Yes / No If yes, Attorney's Name:______________________

Attorney Phone#:____

Have you received any treatment(s) for this condition? Yes / No If yes, please give brief description below:

____

____

Have you had any surgeries related to your condition in the past? Yes / No If yes, please give brief description of previous related surgeries below:

____

____

FOR MEDICAL STAFF ONLY

VS: T HR BP R O2

Name:
Acct #:
Date:

HEALTH HISTORY FORM - PFSH

DOB:________ M / F Height:________ Weight:________ BMI:________ R / L Handed Occupation:________

Please list any **ALLERGIES or REACTIONS** to **Latex, Iodine, Metal** or any **Medication**. ☐ I have none of these allergies.

1. 3. 5.
2. 4. 6.

List all **MEDICATIONS**/**Herbs/Vitamins and Supplements** that you are **currently taking**:

☐ Check Box if separate list has been provided 3. 6.
1. 4. 7.
2. 5. 8.

List all **SURGERIES** that you have had **with approximate dates** of each surgery:

1. 3. 5.
2. 4. 6.

MEDICAL HISTORY

	NO	YES	
High Blood Pressure	____	____	
Heart Attack/Coronary Artery Disease	____	____	
Irregular Heart Beat	____	____	If yes, do you have a **Pacemaker**? Yes / No
Stroke/Paralysis	____	____	
Blood Clots/Pulmonary Embolism	____	____	
Diabetes	____	____	
Kidney Failure/Disease	____	____	If yes, are you on **Dialysis**? Yes / No
Rheumatologic Condition	____	____	
Hepatitis/Liver Disease/HIV	____	____	
MRSA	____	____	
Cancer	____	____	If yes, Type of Cancer/Description:________

	NO	YES
Asthma/Emphysema	____	____
Bleeding Disorder/Anemia	____	____
Intestinal Bleeding/Ulcer	____	____
Hypothyroid	____	____
Hyperthyroid	____	____
Seizures	____	____
TB	____	____
Reaction to Anesthesia	____	____

Other:________

FAMILY HISTORY

	NO	YES
Stroke	___	___
Heart Attack	___	___
Diabetes	___	___
Reaction to Anesthesia	___	___
Bleeding Disorder or Anemia	___	___
Cancer	___	___

Type:________

SYSTEMS REVIEW - Have you **recently** had problems with any of the following?

	NO	YES	**DESCRIPTION (If Yes**, provide a description and indicate if condition is resolved)
Cold/Flu	____	____	________
Eye/Ear	____	____	________
Intestinal	____	____	________
Heart	____	____	________
Breathing	____	____	________
Skin	____	____	________
Nerve	____	____	________
Urinary	____	____	________
Bleeding	____	____	________
Depression/Anxiety	____	____	________

SOCIAL HISTORY

Do you **SMOKE**? ____**NEVER DID** or ____**QUIT**, I have not smoked since: ________ or ____**YES**, I smoke ______cigarettes per day
Do you use **RECREATIONAL DRUGS** (including Marijuana)? ____**NO** or ____**YES**
Do you drink **ALCOHOL?** ____**NO** or ____**YES**, number of drinks per day______, week______, month______
What sport(s) do you participate in or activities do you do for **EXERCISE**? ________

High School Attended:________ College Attended:________