UNIVERSITY FOOT & ANKLE CENTERS

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Medical History Form

Name: _____ Date: _____

Age: _____ Physician who referred you: _____

Is your visit b/c of an injury? Yes/No Date of Injury: _____

Did the injury happen at work? Yes/No Date of Injury: _____

Where is the pain? Right/Left/Both? How long have you had symptoms? _____

Describe the symptoms: _____

_____

Have you had any X-rays or tests for this condition? Yes/No Where? _____

Have you had previous treatment? Yes/No If yes, please describe what kind of treatment:

_____

Has this foot/ankle been injured before? Yes/No If yes, please describe:

_____

Past Medical History

Do/Did you ever have any of the following? Please circle

Abnormal Bleeding
AIDS
Anemia
Asthma
Blood Clots
Chemotherapy
Convulsions/Epilepsy
Depression/Anxiety
Diabetes (I or II)
(Last Hemoglobin A1C) _____ Date_____
Fever, Chills, Sweats
Glaucoma
Headaches
Heart Trouble
Herpes
High Blood Pressure
Kidney Disease
Liver Disease
Lung Disease
Marked Weight Loss
Radiation Treatment
Reaction to Anesthetic
Recent Cold/Flu
Rheumatic Fever
Sinus Problems
Stomach Problems
Stroke
Swollen Glands
Thyroid Disease
Venereal Disease
Other: _____

Medical History Form cont.:

Medications & Dosage (continue of back if need):

_____ _____
_____ _____
_____ _____
_____ _____

Allergies to medications and type of reaction (hives, difficulty breathing, nausea, etc.):

_____

List of previous surgeries:

_____
_____

Family Health Problems (What health problems run in your family? Is the family member living/decease?):

Mother: _____

Father: _____

Brother/Sister: _____

Do you smoke? Yes/No Current every day smoker – Current some day smoker – Former smoker?

Do you drink alcohol? Yes/No How many drinks per week? _____

Height: _____ Weight: _____

Race: _____ Ethnicity: _____

Primary Care Physician: _____

Pharmacy Location: _____

Patient/Guardian Signature:_____