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MEDICAL HISTORY

Patient Name: Date:

What is the reason for your visit?

What is the date of your injury or onset of your symptoms?

Where is the problem site?

☐ Left ☐ Right ☐ Ankle ☐ Foot ☐ Heel ☐ Toes

☐ Other:

Describe your symptoms:

☐ Pain ☐ Swelling ☐ Numbness ☐ Tingling ☐ Burning

☐ Pain with Activity ☐ Pain at Rest

☐ Other:

What previous treatments have you had?

☐ Orthodontics ☐ Medication ☐ Physical Therapy

☐ Injection ☐ Surgery

☐ Other:

Pain Assessment

Indicate pain level on scale of 1-10, 10 being the worst pain.

1 2 3 4 5 6 7 8 9 10

Current Medication(s) *Please include dosage*

Allergies ☐ *None*

☐ Latex ☐ Penicillin ☐ Sulfa

☐ Codeine ☐ Aspirin ☐ Anti-Inflammatory

☐ Lidocaine ☐ Novocain ☐ Local Anesthetic

☐ Adhesive Tape ☐ Iodine ☐ Seafood

☐ Other:

Health History

☐ Arthritis (Type: ☐ Rheumatoid ☐ Osteo ☐ Degenerative)

☐ Diabetes (☐ TYPE I DM ☐ Type II DM)

☐ Cancer Type:

☐ Neuropathy ☐ Circulation Problems ☐ Gout

☐ Fibromyaigia ☐ Artificial Heart Valve ☐ Asthma

☐ Hypertension ☐ Congestive Heart Failure ☐ Stroke

☐ Hypotension ☐ Respiratory Problems ☐ Epilepsy

☐ Heart Problems ☐ Kidney Dysfunction ☐ Fainting

☐ Low Back Pain ☐ Liver Disease ☐ Hepatitis

☐ HIV/AIDS ☐ Unexplained Weight Loss ☐ Obesity

☐ Other:

Surgical History

Surgical Procedure/Complications	Date

Hospitalization

Reason/Procedure	Date

Family History

FATHER: ☐ Alive ☐ Deceased ☐ Unknown

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke

☐ Mental Illness ☐ Cancer Type:

☐ Other:

MOTHER: ☐ Alive ☐ Deceased ☐ Unknown

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke

☐ Mental Illness ☐ Cancer Type:

☐ Other:

SIBLINGS: No. of Siblings: ☐ *None*

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke

☐ Mental Illness ☐ Cancer Type:

☐ Other:

Continue on the back ➥

Social History

Tobacco Use:

☐ Current Smoker ☐ Former Smoker ☐ Non-Smoker *(skip to next section)*

How often do *(did)* you chew tobacco?

☐Often ☐Occasionally ☐Rarely ☐Never

How often do *(did)* you smoke cigarettes?

☐ Everyday ☐ Some days, but not everyday

How many cigarettes a day do *(did)* you smoke?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

How soon after you wake up do *(did)* you smoke?

☐ Within 5 minutes ☐ 6-30 minutes
☐ 31-60 minutes after ☐ 60 minutes

Are you interested in quitting? ☐ N/A

☐ Ready to quit ☐ Thinking of quitting ☐ Not Interested

Alcohol Use:

Did you have a drink containing alcohol in the past year?

☐ Yes ☐ No *(skip to next section)*

How often did you have a drink containing alcohol?

☐ Monthly or less ☐ 2-3 times a week
☐ 2-4 times a month ☐ 4 or more times a week

How many drinks do you have on a typical day?

☐ None ☐ 1-2 drinks ☐ 3-4 drinks
☐ 5-6 drinks ☐ 7-9 drinks ☐ 10 or more drinks

How often did you have 6 or more drinks on one occasion?

☐ Never that much on one occasion ☐ Less than monthly
☐ Monthly ☐ Weekly ☐ Daily or almost daily

Drug Use:

Have you ever used recreational drugs? ☐No ☐Yes

If so, type(s): _____

Have you ever abused prescription drugs? ☐No ☐Yes

If so, type(s): _____

How often do you use: ☐Often ☐Occasionally ☐Rarely ☐Never

Have you ever been treated for drug abuse? ☐No ☐Yes

If so, when: _____

Well Being:

Height:_____ft. _____in. Present Weight: _____lbs.

Shoe Size: _____ ☐ Mens ☐ Womens

Rate your overall well-being/health: ☐ Good ☐ Fair ☐ Poor ☐ Bad

Rate your overall
weight management: ☐ Good ☐ Fair ☐ Poor ☐ Bad

How many days per week do you exercise?

☐ Never ☐ 1-2 ☐ 2-3 ☐ 4 or more

Length of time spent exercising during one session? _____

Do you feel like weight is an issue for your overall health and well-being? ☐ Always ☐ Often ☐ Occasionally ☐ Never

Woman Only

Are you pregnant? ☐Yes ☐No

Are you breast feeding? ☐Yes ☐No

Review of Symptoms

Please select any symptoms you have had in the past 3 months.

General:

☐ Fever ☐ Weight Loss
☐ Chills ☐ Weight Gain ☐ Fatigue

Head:

☐ Headache ☐ Neck Pain
☐ Visual Problems ☐ Hearing Problems

Endocrine:

☐ Heat Intolerance ☐ Hot Flashes
☐ Cold Intolerance ☐ Changes in Hair/Skin Textures

Respiratory:

☐ Cough ☐ Wheezing
☐ Pain in Breathing ☐ Shortness of Breath

Cardiovascular:

☐ Chest Pain ☐ Leg Pain when walking
☐ Palpitations ☐ Dizziness

Gastrointestinal:

☐ Abdominal Pain ☐ Heartburn
☐ Change in Bowel Habits ☐ Difficulty Swallowing

Hematology:

☐ Bruising ☐ Abnormal Bleeding
☐ Delayed Healing ☐ Blood Clots

Urinary:

☐ Painful Urination ☐ Frequent Urination
☐ Blood in Urine ☐ Incontinence

Mucsculosketal:

☐ Painful Joints ☐ Joint Stiffness
☐ Swollen Joints ☐ Cramping ☐ Weakness in Limbs

Skin:

☐ Rash ☐ Skin Lesion(s)
☐ Itching ☐ Wounds/Ulcers

Neurological:

☐ Tingling/Numbness ☐ Tremors
☐ Paralysis ☐ Seizures

Psychiatric:

☐ Anxiety ☐ Insomnia
☐ Depressed ☐ Mood ☐ Memory loss

The information provided is true to the best of my knowledge.

Patient Name *(please print)*: _____ Patient's Guardian *(if applicable, print)*: _____

Patient's or Guardian Signature: _____ Date: _____