

# MEDICAL HISTORY

Timonium Foot and Ankle Center

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Timonium, MD 21093

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Patient: \_\_\_\_\_ Date: \_\_\_\_\_

What is your current foot problem? \_\_\_\_\_

How long has it bothered you? \_\_\_\_\_

Describe the type of pain: Burning \_\_\_\_ Sharp \_\_\_\_ Throbbing \_\_\_\_ Aching \_\_\_\_

Has the condition been treated? Yes \_\_\_ No \_\_\_ If yes, how \_\_\_\_\_

Is the condition getting better or worse? \_\_\_\_\_

Is there a history of injury? \_\_\_\_\_

Any foot problems in the past? \_\_\_\_\_

## PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

Diabetes Mellitus _____	Cancer _____	List all others: _____
High blood pressure _____	Epilepsy/Seizure disorder _____	_____
High Cholesterol _____	Kidney disease _____	_____
Heart Disease _____	Liver Disease _____	_____
Gout _____	Circulation Disorder _____	_____
Stroke _____	Asthma _____	_____

## MEDICATIONS

Please bring a list of your medications to our office for our staff to copy. If you have a list with you today, please give it to our staff so they may place it into your medical record.

List all current medications: \_\_\_\_\_

## ALLERGIES (CHECK ALL THAT APPLY)

Penicillin _____	Codeine _____	List any others: _____
Sulfa drugs _____	Adhesive tape _____	_____
Erythromycin _____	Latex _____	_____
Iodine _____	Novocaine _____	
Morphine _____	Aspirin _____	

## PAST SURGICAL HISTORY

List all surgeries and the date of procedure: \_\_\_\_\_

## SOCIAL HISTORY

Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Do you have children? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many? \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many packs/day? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_

Do you use alcohol? Never \_\_\_\_\_ Rarely \_\_\_\_\_ Moderately \_\_\_\_\_ Heavy \_\_\_\_\_ Drinks/per day \_\_\_\_\_

Do you currently or have you in the past used illicit drugs? Yes \_\_\_ No \_\_\_ If yes, explain \_\_\_\_\_

What is your past or current job? \_\_\_\_\_

Please fill out the reverse side

**FAMILY HISTORY (CHECK ALL THAT APPLY)**

Heart Disease \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ List all others: \_\_\_\_\_  
Diabetes \_\_\_\_\_ Kidney Disease \_\_\_\_\_  
Stroke \_\_\_\_\_ Liver Disease \_\_\_\_\_  
Cancer \_\_\_\_\_ Arthritis \_\_\_\_\_

**REVIEW OF SYSTEMS (CIRCLE ALL CURRENT CONDITIONS)**

**GENERAL GOOD HEALTH**

**CONSTITUTIONAL SYMPTOMS**

Loss of appetite  
Weight loss or gain  
Fever  
Fatigue

**GASTROINTESTINAL**

Nausea  
Vomiting  
Jaundice  
Diarrhea

**NEUROLOGICAL**

Frequent or recurring headaches  
Light-headed or dizzy  
Seizures  
Numbness or tingling sensations  
Paralysis

**GENITOURINARY**

Dialysis  
Kidney disease  
Kidney stones

**PSYCHIATRIC**

Depression  
Insomnia

**HEMATOLOGIC**

Anemia  
Bleeding/Bruising tendencies

**EYES**

Eye disease or injury  
Glaucoma  
Cataract  
Double vision/blurry vision

**MUSCULOSKELETAL**

Joint Pain  
Joint stiffness  
Muscle weakness

**CARDIOVASCULAR**

Chest pain  
Palpitations  
Shortness of breath  
Foot or leg swelling

**RESPIRATORY**

Productive Cough  
Spitting up blood  
Wheezing

**DERMATOLOGIC**

Rash  
Change in nails  
Non-healing wounds

**ENDOCRINE**

Excessive thirst  
Frequent urination  
Heat or cold intolerance

Is there any other information you would like to share about your health? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs Shoe Size \_\_\_\_\_

I have reviewed the patient history and have made note of additional findings \_\_\_\_\_

Jordan R. Stewart, DPM