

MEDICAL HISTORY

Timonium Foot and Ankle Center

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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? _____

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