MEDICAL HISTORY

Timonium Foot and Ankle Center
Jordan R. Stewart, DPM
9622 Deereco Road
Timonium, MD 21093

Patient:______________________________ Date:______________________

PLEASE ANSWER ALL QUESTIONS BELOW

What is your current foot problem?____

How long has it bothered you?____

Describe the quality of your pain: ☐Burning ☐Sharp ☐Throbbing ☐Aching ☐N/A ☐Other________________

Please circle the number that best describes the severity of your condition/pain?

0 1 2 3 4 5 6 7 8 9 10

No pain Mild pain Moderate Pain Severe Pain Worst Pain Imaginable

What are the signs and symptoms associated with your condition? Please check all that apply:

☐Swelling of the foot and/or ankle	☐Drainage	☐Cramping
☐Numbness/Tingling	☐Dry or cracked skin	☐Joint pain
☐Difficulty Walking	☐Odor	☐Joint stiffness
☐Redness	☐Thickening of the nails	☐Muscle weakness
☐Warmth	☐Itching	☐Other:____________________
☐Bruising	☐Nausea/vomiting/Fever/Chills	____________________

When does the condition bother you? Check all that apply:

☐Constantly (All of the time)	☐During the day	☐Never
☐Intermittently (Sometimes/comes and goes)	☐In the evening	☐Other:____________________
☐In the morning		____________________

Has the condition been treated? ☐Yes ☐No If yes, how?________________________________

Is the condition getting ☐ Better or ☐Worse?

What aggravates your condition?

☐Shoes	☐Standing	☐Other:____________________
☐Walking/Running	☐Exercise	____________________

What factors modify/relieve the condition?

☐Rest	☐Soaks	☐Other:____________________
☐Ice	☐Wearing shoes	____________________
☐Elevation	☐Removing shoes	____________________
☐Stretching	☐Skin lotion/creams	
☐Heat	☐Medication; Please list the medication:____________________	

How did your condition present?

☐Acute (Sudden onset)	☐Chronic (Slowly over time)
☐Insidious (Gradual Onset)	☐Other:____________________

Is there a history of foot and/or ankle conditions in the past? ☐Yes ☐No If yes, please explain:____________________

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Patient:______________________________ Date:______________________

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

☐Diabetes Mellitus ☐Cancer. Specify type: __________ ☐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 WITH THE DOSES FOR OUR OFFICE TO COPY)

List all current medications:____

ALLERGIES (CHECK ALL THAT APPLY)

☐Penicillin ☐Codeine ☐List all others:______________________
☐Sulfa Drugs ☐Adhesive Tape
☐Erythromycin ☐Latex
☐Iodine/Shellfish ☐Novocaine
☐Morphine ☐Aspirin

PAST SURGICAL HISTORY (LIST ALL SURGERIES YOU HAVE EVER HAD IN YOUR LIFETIME)

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 per day?_____________
Are you a former smoker? ☐Yes ☐No If yes, when did you quit?____________ How many packs did you smoke per day?_______________
If you are a former smoker, how long did you smoke?_____________________

Do you use alcohol? ☐Never ☐Rarely ☐Socially ☐Moderately ☐Heavily
Do you have a history of alcoholism? ☐Yes ☐No If yes, see below and if no skip to next question.
Are you currently using alcohol? ☐Yes ☐No If no, how long have you been sober?______________________

Do you have a history of illegal drug use? ☐Yes ☐No If yes, which drug/drugs?______________________
If you have a history of illegal drug use, are you currently using illegal drugs? ☐Yes ☐No
If no, when did you last use illegal drugs?______________________

Do you have a history of addiction to prescription pain medication? ☐Yes ☐No If yes, which drug/drugs?__________________
Are you currently taking prescription pain medication? ☐Yes ☐No
If no, when did you last use prescription pain medication?______________________

FAMILY HISTORY (CHECK ALL THAT APPLY). *******__Please indicate mother or father__******

M F ☐HEART DISEASE M F ☐GOUT M F ☐KIDNEY DISEASE
M F ☐DIABETES M F ☐HIGH BLOOD PRESSURE M F ☐PERIPHERAL NEUROPATHY
M F ☐STROKE M F ☐LIVER DISEASE M F ☐List all others:______________________
M F ☐CANCER M F ☐ARTHRITIS

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Patient: ______________________ Date: ______________________

REVIEW OF SYSTEMS

*****PLEASE CHECK ALL THAT CURRENTLY APPLY*****

CONSTITUTIONAL SYMPTOMS
☐Loss of appetite
☐Weight loss
☐Weight gain
☐Fever
☐Fatigue

GASTROINTESTINAL
☐Nausea
☐Vomiting
☐Jaundice
☐Diarrhea

NEUROLOLGICAL
☐Frequent or recurring headaches
☐Light-headed or dizziness
☐Seizures
☐Numbness or tingling sensations
☐Paralysis

GENITOURINARY
☐Dialysis
☐Kidney Disease
☐Kidney Stones

PSYCHIATRIC
☐Depression
☐Anxiety
☐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
☐Dry and/or scaling skin

ENDOCRINE
☐Excessive thirst
☐Frequent urination
☐Heat intolerance
☐Cold intolerance

☐NONE OF THE ABOVE APPLY AND I AM IN GENERAL GOOD HEALTH

Please list any other information you would like to share about your health: ______________________

Height: ______________________

Weight: ______________________

Shoe size: ______________________

I have reviewed the patient history and have made note of additional findings: ______________________
Jordan R. Stewart, DPM