The Foot and Ankle Center of Clarksburg

Medical History

Name: _____ **Date of Birth:**_____ **Date:** _____

PLEASE FILL OUT FORM AS COMPLETELY AS YOU CAN. IT IS IMPORTANT THAT YOUR CHART BE AS COMPLETE AS POSSIBLE. SOME TREATMENTS MAY REQUIRE ALTERATIONS DUE TO INFORMATION BELOW.

Family Physician: _____ **Last Visit:** _____

Past Medical History (please circle)

Diabetes	Heart Disease	Rheumatic Fever	Epilepsy	Polio
High Cholesterol	Breathing Disease	Scarlet Fever	Measles	Mumps
High Blood Pressure	Arthritis Diseases	Bleeding Disorders	Cancer	Gout
Heart Attack	Thyroid disease	Kidney/ liver disease		

Please List any other health problems not listed above

_____

_____

_____

Medications (please list all medications, dosages, and how many times a day you take them. This should include over the counter medications, vitamins, herbals, and home remedies)

_____

_____

_____

_____

_____

Allergies (please circle and list what happens)

Penicillin	Latex	Lidocaine	Sulfa	Iodine (shellfish)
Narcotics	Adhesives (tape)			

Any other allergies?

_____

_____

_____

_____

Surgeries (please list all procedures/ date/ location/ complications)

_____

_____

_____

_____

Hospitalizations (please list all reasons/ date/ location)

_____

_____

_____

Social History

Married	() yes	() no	
Children	() yes	() no	How many? _____
Tobacco	() yes	() no	Packs/cans per day? _____
Alcohol	() yes	() no	How Much? _____
Employed	() yes	() no	Where? _____
Drug Use	() yes	() no	Which? _____
Exercises	() yes	() no	What? _____

Family History (Grandparents, parents, siblings)
Has anyone in your family been diagnosed with these

High Blood pressure	() yes	() no	Epilepsy	() yes	() no
Heart Disease	() yes	() no	Gout	() yes	() no
Diabetes	() yes	() no	Tuberculosis	() yes	() no
Cancer	() yes	() no	Arthritis	() yes	() no
Anemia	() yes	() no	Foot Problems	() yes	() no

Any other diseases that family members have been diagnosed with?

_____

_____

_____

Review of Systems (please circle any that apply to you)
Constitutional: Fever chills gain weight weight loss aches
Gastrointestinanal: Poor appetite excessive hunger Difficulty swallowing
Constipation Excessive thirst Nausea Diarrhea
Genitourinary: Trouble urinating Burning urination Blood in Urine
Kidney disease Kidney Stones
Nervous: Numbness Paralysis Dizziness Fainting Depression
Weakness SeizureConfusion Forgetfulness

Eyes: Eye Strain Vision problems eye disease Impaired sight
Ears/Nose/ Throat: Ear pain Ear discharge Hearing Loss
Nose Bleeding Sore throat Hoarseness Difficulty speaking
Cardiovascular: Chest pain Leg pain with walking Heart attack
High blood pressure Varicose veins Night sweats Feet swell
Respiratory: Persistent cough Difficulty breathing Lung problems
Asthma Shortness of breath wheezing Emphysema
Skin: Itching Rashes Moles Skin Cancers Birth marks Hives
Musculoskelatal: Arthritis Stiffness Joint Diseases Muscle pains
Hematologic: Anemia Take blood thinner Bleeding disorder

Physician Signature: _____ **Date:**_____