MEDICAL QUESTIONNAIRE

PATIENT'S NAME _____
First M.I. Last

AGE _____ **BIRTHDATE** ____/____/_____ **SEX** ☐ M ☐ F **HEIGHT** _____ **WEIGHT** _____ **SHOE SIZE** _____

REASON FOR TODAY'S VISIT: _____ **FIRST DATE OF ONSET:** _____

DID THIS INJURY OCCUR AT WORK? ☐ Yes ☐ No If yes, please describe how the injury occurred: _____
IF YES, HAVE YOU REPORTEDTHIS INJURY TO YOUR EMPLOYER? _____

REFERING DOCTOR: _____ **PRIMARY CARE DOCTOR:** _____

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS PROBLEM? ☐ Yes ☐ No If yes, please specify prior treatment for this problem, including at-home or professional medical treatment: _____

PAST MEDICAL HISTORY (Please √ if you have any of these in the past)

__Anemia
__Arthritis
__Autoimmune Disease
__Bleeding Disorders
__Breathing problems/Lung Disorders
__Cancer, please specify:
_____
__Cellulitis
__Congestive Heart Failure
__Deep Vein Thrombosis
__Diabetes: __ Diet __ Oral __ Insulin
__Fracture History, please specify:
_____
__Fungal Infections
__Gout
__Heart Disease
__High Blood Pressure
__High Cholesterol
__ Gastrointenstinal Reflux/Ulcers/Bleed
__ Kidney Disease/Dialysis
__ Liver Disease
__ Neuropathy
__Osteoporosis
__Peripheral Vascular Disease/Poor Circulation
__Psoriasis
__Rheumatic
__Sciatica/Back Problems
__Seizure Disorder
__Skin Cancer
__Stroke
__Thyroid Problems
__Varicose Veins
__Warts
__Other: _____

CURRENT MEDICATIONS ☐ None ☐ I take the following prescription or over the counter medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES

☐ No known allergies

☐ I have the following allergies: __Penicillin __Shellfish __Sulfa __Codeine __Iodine __Aspirin/NSAIDs __Adhesive/tape __Cortisone __Local anesthetics __Other, please specify: _____

SURGICAL HISTORY/HOSPITALIZATIONS

☐ None

☐ I have had the following surgeries or hospitalizations in the past:

_____Year: _____ _____Year: _____ _____Year: _____

_____Year: _____ _____Year: _____ _____Year: _____

SOCIAL HISTORY

Do you smoke? ☐ Yes, I have smoked for _____ years and _____ packs/day on average

☐ Not currently. I quit _____ years ago after smoking for _____ years and _____ packs/day on average

☐ No, I have never smoked

Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely

Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____

☐ Yes, I had a past substance abuse problem. Please specify: _____

☐ No, I have never had a substance abuse problem.

What is your occupation? _____ Does it involve mostly standing or sitting? _____

Do you exercise regularly? ☐ Yes, I do the following regular exercise: _____

☐ No, I do not exercise regularly.

FAMILY HISTORY (Please specify if your parents or siblings had any of the following health conditions):

__Diabetes __Circulatory Problems __Heart Disease __Gout
__Hypertension/High Blood Pressure __Other: _____

REVIEW OF SYSTEMS (Please √ if you currently have any of these symptoms)

Cardiovascular

__leg pain when walking
__chest pain __chest pressure/angina
__leg swelling __cold hands or feet
__leg cramps __high blood pressure/hypertension

Eyes, Ear, Nose, Mouth, Throat

__dizziness __glaucoma
__hearing loss __ cataracts
__vision problems

Gastrointestinal

__abdominal pain __heartburn
__blood in stool __vomiting
__ulcers __diarrhea
__indigestion

Hematologic

__ sickle cell disease __clotting disorders
__anemia __bleeding problems
__use of blood thinners

Musculoskeletal

__back pain __joint swelling
__muscle weakness __muscle pain
__neck pain __sciatica
__joint pain __joint stiffness
__arthritis __joint instability

General

__nausea __fever
__vomiting __chills
__weight gain or weight loss

Endocrine

__dry hair __cold intolerance
__dry eyes __weight changes
__thyroid problems

Genitourinary

__currently pregnant __excessive urination
__kidney disease __kidney stones

Integumentary

__athletes foot __nail abnormalities
__keloids __itchiness
__dry, scaly skin __lower leg ulcers
__rash

Neurological

__tingling __weakness
__seizures __numbness
__tremors __paralysis

Respiratory

__chest pain __difficulty breathing
__wheezing __coughing
__snoring __shortness of breath

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment at Total Foot and Ankle Center, LLC, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

_____ _____

Patient/Parent/Guardian **Date**