Patient Medical History Form

PETOSKEY FAMILY FOOT CARE

Dr. Anthony Robert Alessi, DPM, PC

Patient Name _____ Date

Family Physician

Dr. Name: _____ *Phone:* _____

*Address:*_____

Primary Hospital Affiliation: _____

Any Specialty Physicians being seen*:*

Name: _____*/Phone:*_____*/ Condition being Treated:*_____

Name: _____*/Phone:*_____*/ Condition being Treated:*_____

Name: _____*/Phone:*_____*/ Condition being Treated:*_____

Please describe the condition(s) that brought you in today:

_____

_____

_____

_____

#1 concern_____ #2 concern_____ #3 concern_____

Is the discomfort (Please circle one):

◯*Burning* ◯*Throbbing* ◯*Sharp* ◯*Dull* ◯*Aching* ◯*Other (Describe)*_____

THE *SEVERITY* OF DISCOMFORT/PAIN OF YOUR MAIN PROBLEM *(Please circle one):*

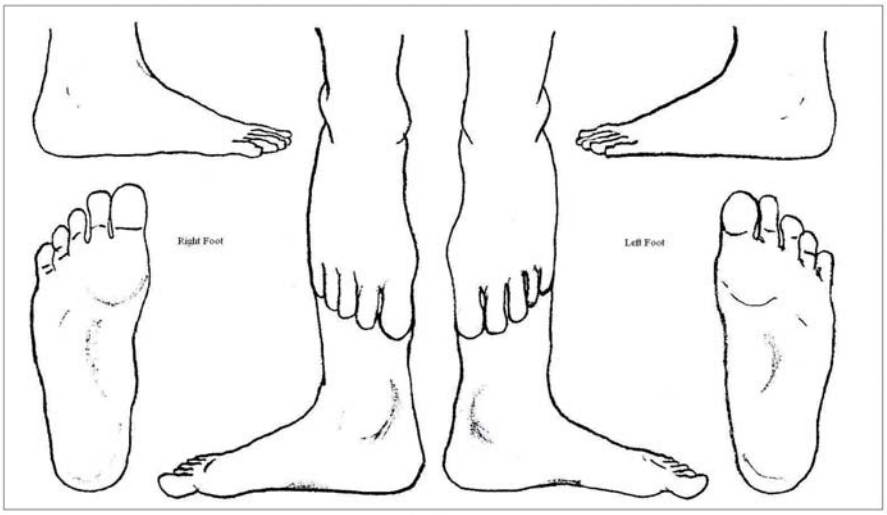
Rating at its worst:

mild ◯**1** ◯**2** ◯**3** ◯**4** ◯**5** ◯**6** ◯**7** ◯**8** ◯**9** ◯**10** **unbearable**

Patient Name: **Date:**

HISTORY OF PRESENT ILLNESS (HPI): PLEASE BRIEFLY ANSWER THE FOLLOWING QUESTIONS:

Locate the areas of your concern:



When did your problem begin: _____ DAYS _____ MONTHS _____YEARS

ONSET: ◯ *GRADUAL* ◯ *SUDDEN* *EXPLAIN:*

Is the problem getting worse, better or staying the same? ◯ *WORSE* ◯ *BETTER* ◯ SAME

What seems to affect the problem? When is it better:

When is it worse:

Have you had this treated before? ◯ NOT TREATED

◯ ANOTHER DR. TREATED IT (who when, & how):

◯ I TREATED IT AT HOME (how):

Patient Name: **Date:**

Was this caused by an injury? ◯ NO ◯ YES

When:

Where:

How:

Who is the billing company:

Do you have any OTHER foot problems that need attention: ◯ NO ◯ YES

If yes, please list those problems in order of importance on a separate piece of paper and describe them.

PLEASE LIST ALL MEDICATIONS AND VITAMINS THAT YOU ARE TAKING:

(try to include the dosages and frequency that you are taking your medications or vitamins) ☐ None

_____

_____

_____

_____

ALLERGIES/INTOLERANCES (DESCRIBE REACTION):

NO KNOWN DRUG ALLERGIES ☐

◯ Penicillin_____ ◯ Cortisone_____

◯ Codeine_____ ◯ Shellfish_____

◯ Iodine_____ ◯ Sulfa_____

◯ Aspirin_____ ◯ Local Anesthesia_____

◯ Tape_____ ◯ Latex_____

◯ Other_____

Patient name: **Date:**

Please check any condition(s) you are currently experiencing or have experienced in the past:

☐ Anemia	☐ High Cholesterol
☐ Anxiety	☐ HIV/AIDS
☐ Arthritis	☐ Kidney Disease
☐ Asthma/Emphysema	☐ Liver Disease
☐ Back Pain	☐ Muscular disorders/diseases
☐ Bleeding disorders/Blood clots	☐ Neurological disorders/disease
☐ Cancer	☐ Previous problems with anesthesia
☐ Current pregnancy	☐ Seizures/Epilepsy
☐ Dementia	☐ Sexually Transmitted Disease
☐ Depression	☐ Sleep Apnea
☐ Diabetes	☐ Stomach ulcers/GERD/IBS
☐ Difficulty healing	☐ Stroke
☐ Gout	☐ Thyroid Disease
☐ Heart Disease	☐ Trouble breathing- Lung Problems
☐ High Blood Pressure	☐ Tuberculosis

Please describe any other medical condition(s) not listed above:

_____

_____

_____

_____

Height:_____ Weight:_____ Shoe size:_____

Blood Pressure:_____ Heart Rate/Pulse:_____ BMI:_____

Are you Pregnant? ◯ Yes ◯ No (last menstrual period_____) ◯ N/A-Male

ARE YOU IN: ◯ GOOD HEALTH ◯ FAIR HEALTH ◯ POOR HEALTH

Patient Name: **Date:**

PAST SURGICAL HISTORY/HISTORY OF HOSPITALIZATIONS

Please describe any surgeries or hospitalizations that you have had, if any. ☐ **NONE**

☐

_____

_____

_____

Past History of any foot problems (not discussed above): ☐ **NONE**

_____

_____

_____

FAMILY HISTORY

Do you have a family history of any conditions such as **Diabetes**, **Heart Disease**, **Blood Clots**, **Bleeding Problems**, **Strokes**, **Gout**? ☐ **NO**.
If Yes, which condition and which family member? Also list any conditions not listed above:

_____

_____

_____

SOCIAL HISTORY

What is your occupation?_____

Does your occupation/lifestyle require you to spend large amounts of time on your feet? If yes, please describe_____

Do you exercise? ☐ NO ☐ Yes (how often and how much) _____

Have you ever smoked? ☐ NO ☐ Yes

Do you currently smoke? ☐ NO ☐ Yes (Amount and how long)_____

Do you drink alcohol? ☐ NO ☐ Yes (how often and much)_____

Do you drink caffeinated beverages? ☐ NO ☐ Yes (how often and much)_____

DO YOU USE ILLICIT DRUGS SUCH AS MARIJUNA, COCAINE… ☐ NO ☐ YES
(EXPLAIN)_____

_____

_____

Patient Name: **Date:**

REVIEW OF SYSTEMS

Please circle any problems you are currently experiencing

CONSTITUTIONAL

decreased appetite ▪ faintness ▪ dizziness ▪ headache ▪ fever ▪ difficulty breathing when lying flat feeling as if room is spinning ▪ weakness ▪ unexplained weight loss ▪ unexplained weight gain ▪ N**ONE** ☐

CARDIOVASCULAR

chest or arm pain ▪ blood clots ▪ cramps in legs or feet when walking ▪ high blood pressure ▪ low blood pressure ▪ heart attack ▪ heart murmur ▪ heart palpitations ▪ stroke ▪ varicose veins ▪ mitral valve prolapse ▪ **NONE** ☐

MUSCULOSKELTAL

joint ache or pain ▪ chronic neck pain ▪ chronic hip pain ▪ chronic low back pain ▪ chronic ankle pain ▪ stiffness ▪ morning stiffness ▪ weakness ▪ pain in the feet in the morning ▪ pain upon rising anytime ▪ swelling of joints ▪ limited motion in joints ▪ cramps in legs or feet when sleeping ▪ **NONE** ☐

INTEGUMENT

allergy to chemicals ▪ scarring ▪ dry skin ▪ itchy skin ▪ cracking skin ▪ thick or discolored toenails ▪ thick or discolored fingernails ▪ skin rash ▪ scarring after surgery or injury ▪ skin cancer pain associated with skin ▪ **NONE** ☐

NEUROLOGICAL

tingling ▪ pins and needles ▪ numbness ▪ increased sensitivity to touch ▪ burning ▪ decreased or lack of sensation to touch ▪ shooting pain ▪ decreased or lack of sensation to heat or cold ▪ radiating pain ▪ **NONE** ☐

ENDOCRINE

increase or decrease in thirst ▪ increase or decrease in urination ▪ diabetes mellitus ▪ thyroid problems ▪ post-menopause ▪ **NONE** ☐

HEMATOLOGICAL/LYMPHATIC

hemophilia ▪ anemia ▪ bruise easily ▪ blood transfusion reaction ▪ leukemia ▪ sickle cell disease or trait ▪ weakness ▪ yellow discoloration of the skin ▪ **NONE** ☐

Patient Signature_____ Date_____

Physician Signature _____ Date _____