

Foot & Ankle Clinic of Spokane, Inc.
CONFIDENTIAL PATIENT HISTORY FORM

Patient Name _____ DATE OF VISIT _____
Height _____ Weight _____ Shoe Size _____ OFFICE USE ONLY: TEMP _____ BP _____ P _____

Describe your main foot/ankle problem: _____

When did your problem begin? _____

Locate the exact area of the problem _____

How does this condition limit your from doing normal activities? Cannot walk without pain Cannot jog/golf
 Other (List) _____

Do you have other foot/ankle problem needing attention? _____

CIRCLE TYPE OF PAIN: THROB/ SHARP SHOOTING / DULL / ACHE/ TINGLING /SORE / NUMB

What makes the problem worse? Walking Shoes Exercise Other(list) _____

Was it caused by injury? Yes No If Yes, state DATE and circumstances _____

What have you tried to make it better? Shoes Soaked Rubbed Other (list) _____

RATE YOUR PAIN OR DISCOMFORT 0 (no pain) 1-2-3-4-5-6-7-8-9-10 (excruciating)

List ALLERGIES TO MEDICATIONS _____

List Previous Injuries or accidents _____

Do you have Diabetes Heart Problems Hypertension Bleeding Tendencies

Other Disease/Illness _____

List your operations/ hospitalization and the year: _____

List all your MEDICATIONS and dosages: _____

FAMILY HISTORY: Is there a family (blood relative) history of Diabetes Heart disease Arthritis Cancer
Lung disease Foot problems Other (list) _____

SOCIAL HISTORY: Occupation _____ Married /Single Do you have children? _____

How is their health? _____ Are your parents /siblings living? _____ If yes how is their Health ? _____

Do you/Did you smoke? Yes No No of years _____ How much per day _____ Quit date _____

Do you/Did you ingest alcohol? Yes No Never Rarely Socially Occassionally

REVIEW OF SYSTEMS: Check any of the following that apply at the present visit:

- | | | |
|---------------------------------|--------------------------------------|------------------------------------|
| Skin Rash/ itching _____ | Skin/Hair/Nail Changes _____ | Head Trauma _____ |
| Headaches _____ | Eyeglasses _____ | Hearing loss _____ |
| Nose Bleeds _____ | Sinus Problems _____ | Dental Problems _____ |
| Dentures _____ | Lungs /Shortness Breath _____ | Wheezing/Cough _____ |
| Heart /Chest pain _____ | Irregular Heart beat _____ | Hear Murmur _____ |
| Calf Pain _____ | High Blood _____ | Swelling _____ |
| GI Weight loss _____ | Weight Gain _____ | Loss of Appetite _____ |
| Nausea/Vomiting _____ | Abdominal Pain _____ | Urinary Infection _____ |
| Back Pain _____ | Joint Pain _____ | Stiffness _____ |
| Muscle Cramps _____ | Numbness/weakness _____ | Neurological: Seizure _____ |
| Paralysis _____ | Tingling _____ | Speech Problem _____ |
| Mental: Anxiety _____ | Insomnia _____ | Balance Problems _____ |