



North Texas Foot and Ankle Specialists, P.C.

Medical History

General History

Full Name: _____ Occupation: _____
 Gender: (circle) M or F Age: _____ DOB: _____ Weight: _____ Height: _____ Shoe Size: _____
 Chief Complaint: _____ Family Doctor: _____ Last Seen: _____
 Related to: Work: *Yes/ No/ Maybe Auto: *Yes/ No/ Maybe Accident: *Yes/ No/ Maybe Are you pregnant? Yes/ No/ Maybe
 Smoking: Packs/day: _____ Years: _____ Past Smoker: Packs/day _____ Years: _____
 Caffeine: Quantity _____ Alcohol: None Rarely Moderately Daily Quit
 Recreational Drug Use: None Moderately Daily Quit
 List Athletic activities: _____ Amount per day/week: _____
 Employment requires you to: (circle which apply) Sit Stand Sit and Stand Stand and Walk Not Employed
 Have you ever been to a Podiatrist before: Yes/No. If yes, please list. Name: _____ Last Seen: _____
 Have you ever worn orthotics/arch supports? Yes/No. If yes, what kind: _____
 Who referred you to us? _____

History Of : Do you have or have you ever been treated for: (circled items to indicate YES)

AIDS/HIV	Bunions	Fibromyalgia	Low Blood Pressure	Special Diet
Anemia	Chest Pain	Flat Feet	Lung Disease	Sports Related Injuries
Angina	Chemical Dependency	Gout	Nervous Problems	Stomach Ulcers
Ankle Pain	Cancer	Headaches	Osteoporosis	Stroke
Arthritis	Circulatory Problems	Heart Disease	Phlebitis	Swelling in Ankles/Feet
Artificial Heart Valves	Corns and Calluses	Heel Pain	Plantar Warts	Tired Feet
Artificial Joints	Depression	Hemophilia	Radiation Treatment	Thyroid Disorder
Asthma	Diabetes	High Blood Pressure	Rash	Tuberculosis
Athlete's Foot	Ear Problems	Ingrown Toenails	Rheumatic Fever	Varicose Veins
Back Problems	Eye Problems	Kidney Problems	Seizure Disorders	Venereal Disease
Bleeding Disorders	Fainting	Liver Disease	Sinus Problems	Weight Loss, unexplained

Sensation History: Night Pain Burning Tingling Swelling Cramps/Numbness in Feet or Legs Calf Pain

Pain Level: Please circle the number on the pain scale that best represents your level of pain at this moment.

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
 (zero: NO Pain) (ten: Worst possible pain)

Family History

List Relationship to you of family members who have had: Foot Problems: _____
 Arthritis: _____ Diabetes: _____ Heart Problems: _____

Past Surgical Procedures/other Hospitalization:

Surgical History	Date	Hospitalization History	Date
_____	_____	_____	_____
_____	_____	_____	_____

Previous Blood Transfusions: Yes/ No Exposure to Hepatitis: Yes/ No

Medications (please attach additional list if they apply)

Include prescriptions, over-the-counter medications and vitamins: _____

Pharmacy Name: _____ Location: _____ Phone #: _____

Allergies

Are you allergic to any of the following: (circle what applies and note any reactions) or CIRCLE: **No Known Allergies**

Adhesive/Tape: _____	Anticoagulants: _____	Aspirin: _____
Codeine: _____	Demerol: _____	Iodine: _____
Local Anesthetics: _____	Novocain: _____	Penicillin: _____
Seafood: _____	Sulfa: _____	Other: _____

Print Patient's Name: _____ Signature of Patient/Guardian: _____ Date: _____