

# History and Physical

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Chart Number: \_\_\_\_\_

**Medical History:**

|   |  |  |   |   |   |
|---|--|--|---|---|---|
| <input type="checkbox"/> Alcoholism                 | <input type="checkbox"/> Blood disorders                 | <input type="checkbox"/> Circulation problems      | <input type="checkbox"/> Musculoskeletal  | <input type="checkbox"/> Breathing issues |   |
| <input type="checkbox"/> Liver                      | <input type="checkbox"/> Sleep apnea                     | <input type="checkbox"/> Gout                      | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Heart disease    | <input type="checkbox"/> Asthma         |
| <input type="checkbox"/> Heart murmur               | <input type="checkbox"/> Stomach/bowel                   | <input type="checkbox"/> Depression                | <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Mental illness   | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Blood clot                 | <input type="checkbox"/> High cholesterol                | <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Hepatitis        |   |
| <input type="checkbox"/> Neuropathy (specify) _____ | <input type="checkbox"/> Thyroid disease (specify) _____ | <input type="checkbox"/> Diabetes (type 1, type 2) | <input type="checkbox"/> HIV              | <input type="checkbox"/> CVA              |   |
| <input type="checkbox"/> Arthritis (specify) _____  | <input type="checkbox"/> other (specify) _____           | <input type="checkbox"/> Skin disorders            | <input type="checkbox"/> Stroke           |   |   |

**Are you pregnant?**  Yes  No    **Are you nursing?**  Yes  No

**Surgical History**  None  Appendectomy  C-Section  Angioplasty  Bypass  Cataracts  Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you have any artificial joints?  Yes (where? \_\_\_\_\_)  No    Do you have an artificial heart valve?  Yes  No

## Social History

Do you smoke?  Yes  No If yes how many packs per day?  1  2  3  4  5 For how long? \_\_\_\_\_

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?  No, I do not exercise regularly  Yes, I do the following regular exercise: \_\_\_\_\_

## Family History

 Is there any family history (blood relative) of: (Please indicate family member)

|   |  |
|---|--|
| <input type="checkbox"/> Alzheimer's _____          | <input type="checkbox"/> Depression _____          |
| <input type="checkbox"/> Arthritis _____            | <input type="checkbox"/> Diabetes _____            |
| <input type="checkbox"/> Bleeding disorders _____   | <input type="checkbox"/> Emphysema _____           |
| <input type="checkbox"/> Blood clot _____           | <input type="checkbox"/> Heart disease _____       |
| <input type="checkbox"/> Cancer _____               | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cataracts _____            | <input type="checkbox"/> Neurological _____        |
| <input type="checkbox"/> Circulation problems _____ | <input type="checkbox"/> Strokes _____             |
| <input type="checkbox"/> Other (specify): _____     |  |

## Review of Systems

 (Please check the box if you currently have any of these symptoms or check "NONE")

|                         |  |  |  |  |   |                                       |
|-------------------------|--|--|--|--|---|---------------------------------------|
| <b>Cardiovascular</b>   | <input type="checkbox"/> leg pain when walking | <input type="checkbox"/> fever               | <input type="checkbox"/> chest pain/pressure | <input type="checkbox"/> leg swelling      | <input type="checkbox"/> cold hands/feet    |                                       |
|                         | <input type="checkbox"/> fainting              | <input type="checkbox"/> palpitations        | <input type="checkbox"/> vascular disease    | <input type="checkbox"/> valve problems    | <input type="checkbox"/> NONE               |                                       |
| <b>Genitourinary</b>    | <input type="checkbox"/> blood in urine        | <input type="checkbox"/> hesitancy           | <input type="checkbox"/> incontinence        | <input type="checkbox"/> increased urgency |   |                                       |
|                         | <input type="checkbox"/> decreased frequency   | <input type="checkbox"/> excessive urination | <input type="checkbox"/> kidney disease      | <input type="checkbox"/> kidney stones     | <input type="checkbox"/> NONE               |                                       |
| <b>Gastrointestinal</b> | <input type="checkbox"/> abdominal pain        | <input type="checkbox"/> heartburn           | <input type="checkbox"/> blood in stool      | <input type="checkbox"/> vomiting          | <input type="checkbox"/> ulcers             | <input type="checkbox"/> constipation |
|                         | <input type="checkbox"/> diarrhea              | <input type="checkbox"/> trouble swallowing  | <input type="checkbox"/> decrease appetite   | <input type="checkbox"/> increase appetite | <input type="checkbox"/> NONE               |                                       |
| <b>Integumentary</b>    | <input type="checkbox"/> athlete's foot        | <input type="checkbox"/> nail abnormalities  | <input type="checkbox"/> keloids             | <input type="checkbox"/> itchiness         | <input type="checkbox"/> dry, scaly skin    | <input type="checkbox"/> NONE         |
| <b>Hematologic</b>      | <input type="checkbox"/> lower leg ulcers      | <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> anemia              | <input type="checkbox"/> blood thinners    | <input type="checkbox"/> clotting disorders | <input type="checkbox"/> NONE         |
| <b>Neurological</b>     | <input type="checkbox"/> tingling              | <input type="checkbox"/> weakness            | <input type="checkbox"/> seizures            | <input type="checkbox"/> numbness          | <input type="checkbox"/> headaches          |                                       |
|                         | <input type="checkbox"/> tremors               | <input type="checkbox"/> paralysis           |  |  | <input type="checkbox"/> NONE               |                                       |
| <b>Musculoskeletal</b>  | <input type="checkbox"/> back pain             | <input type="checkbox"/> joint swelling      | <input type="checkbox"/> muscle weakness     | <input type="checkbox"/> muscle pain       | <input type="checkbox"/> neck pain          |                                       |
|                         | <input type="checkbox"/> sciatica              | <input type="checkbox"/> joint stiffness     | <input type="checkbox"/> joint pain          | <input type="checkbox"/> joint instability | <input type="checkbox"/> arthritis          | <input type="checkbox"/> NONE         |
| <b>Respiratory</b>      | <input type="checkbox"/> chest pain            | <input type="checkbox"/> wheezing            | <input type="checkbox"/> COPD                | <input type="checkbox"/> coughing          | <input type="checkbox"/> snoring            |                                       |
|                         | <input type="checkbox"/> shortness of breath   | <input type="checkbox"/> emphysema           |  |  | <input type="checkbox"/> NONE               |                                       |

## PLEASE READ AND SIGN

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

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_