

Reviewed By: _____
Blood Pressure: _____
Pulse: _____
Temp: _____
Height: _____ Weight: _____
Shoe Size: _____ Width: _____

MEDICAL HISTORY QUESTIONNAIRE Foot and Ankle Specialist, P.C.

Patient Name: _____ AGE: _____ Date: _____

How Did You Hear About Us? / Referred By: _____

Chief Complaint: _____ Which side is affected? R _____ L _____

Date Problem Began: _____

(In your own words, please describe) When and where did this problem begin? _____

Additional relevant information: _____

Circle any of the following associated signs / symptoms that you are experiencing:

Swelling	Instability	Locking	Stiffness	Weakness	Bruising
Catching	Grinding	Limited Motion	Tingling	Burning	Numbness

Pain severity: minor, moderate, severe

Pain quality: dull, throbbing, sharp, burning

Pain duration: intermittent, constant

Pain timing: rest, with movement

Pain context: improving, same, worsening

Modifying factors: rest, heat, cold, medications

Previous evaluations/treatments/tests: _____

Past Medical History

Circle any of the following problems that have affected your personal health:

Diabetes	High blood pressure	Heart problems	Stroke	Gout
Blood disorder	Blood clots	Sleep Apnea	Seizure	Arthritis
Cancer	Lung problems	Stomach problems	Kidney problems	Multiple Sclerosis
Thyroid	Other _____			

Surgeries _____

Current medication: _____

List Any Allergies to Medications?

Family Medical History:

Social History:

Tobacco Use: (list amount /years) _____ Alcohol Consumption: (list amount /years) _____ Recreational Drug Use: _____

Sports/Recreational Activities: _____

Patient Signature: _____ Date: _____

(Parent or Guardian if patient is under age 18)