COASTAL FOOT AND ANKLE CLINIC
Initial Patient History

Name: _________________________Birthdate: ___/___/___Today's date: ___/___/___

Primary Doctor: __________________________His/Her address: ____________________

His/Her Phone: _____________ Name of Pharmacy: _________________City:_________

What type of shoe do you normally wear? ________________________Shoe Size:________

ALL PATIENT INFORMATION IS CONFIDENTIAL!

<u>HISTORY OF PRESENT ILLNESS</u>

Describe the MAIN PROBLEM that brings you in today:_____________________________
____
____

Did this problem start suddenly? (circle) YES NO

Which foot/ankle/leg? (circle) RIGHT LEFT BOTH

How long have you had this problem? ____

What have you tried on your own to help this problem?_____________________________
____

<u>PRESENT MEDICAL HISTORY</u>

Please list all HEALTH PROBLEMS (not just foot/ankle):___________________________
____
____

Please list all MEDICATIONS (including over the counter/herbal), the dose and how often you take them: ____
____
____
____

Please list all SURGERIES you have had and the YEAR you had them:
____
____
____

Have you ever had a problem with local or general anesthesia? ( ) NO ( ) YES If yes, please explain:____

Please list all ALLERGIES to foods/medicines: ___________________________________
____
____

FAMILY HISTORY-list any health problems with your first degree relatives

Relative	Medical problem	Age when diagnosed	Their date of birth	Their date of death or N/A
Mom				
Dad				
Sister				
Brother				
Daughter				
Son				

SOCIAL HISTORY
On an average how much of the following do you have PER DAY?
CAFFEINE: ____________SMOKE/CHEW/DIP: ___________or year you quit______
ALCOHOL: ____________________________

REVIEW OF SYSTEMS
Only check if you HAVE HAD or CURRENTLY HAVE any of the following conditions:

CANCER___, location/type__________
SMALL POX___
GLASSES/CONTACTS___
PNEMONIA____
RESPIRATORY DISORDERS___
CIRCULATION PROBLEMS___
SYPHILLIS___
ARTERY DISEASE___
PEPTIC ULCER___
DIFFICULTY SWALLOWING___
GONORRHEA___
HEPATITIS___
DEPRESSION___
MENTAL ILLNESS___
EPILEPSY___
NERVOUS CONDITON___
BACK INJURY___
DEFORMITIES___
HEART ATTACK___
KIDNEY DISORDERS___
RENAL STONES___

MEASLES___
CHICKEN POX___
DENTURES___
TUBURCULOSIS___
HIGH BLOOD PRESSURE___
SCARLET FEVER___
RHEUMATIC FEVER___
BLEEDING DISORDER___
HIATAL HERNIA___
URINARY TRACTINFECTION___
LIVER CIRRHOSIS___
LIVER DISORDERS___
THYROID PROBLEMS___

MENINGITIS___
SPINAL DEFECT___
FRACTURES___
BIRTH DEFECTS___
HEART FAILURE___
DIFFICULTY URINATING___
DIABETES MELLITUS___IF YES, TAKING INSULIN___

MUMPS___
ASTHMA___
COPD___
STROKE___
HIV____
GOUT___
POLIO___

OTHER ____