Metro Foot and Ankle- History

Chief Complaint:_____

_____

_____

Onset, when did it start?_____

Type of pain, What makes it worse? _____

What helps? _____

Home /professional treatments?_____

Medical Issues::_____

_____

_____

Are you Pregnant? Or nursing?_____

Current Medication:_____

_____

_____

Drug Allergies : please Circle and describe reaction. _____

Penicillin Sulfa Codeine lidocaine Aspirin/Motrin Tape Other _____

Do you Smoke? _How much?_____

Do you use recreational Drugs?_____ Last time _____

Do you use Alcohol?_____How often and much?_____

General: fever, weight loss or gain, night sweats, loss of appetite? _____

Dermatological: rash, itch, growth or mass, hair loss? _____

GI: heartburn, reflux, bloody stool, diarrhea, nausea, bleeding, ulceration? _____

Cardio-pul: cough, difficulty breathing, shortness of breath, wheeze palpation, pain, arrythmia_____

Neurological: Balance issue, numbness, tingling, weakness back pain? _____

Musculoskeletal: Joint pain, gait abnormality, autoimmune issues bone issues?_____

ENT: vision abnormalities, glaucoma, sore throat, thyroid, _____

Hematology: Bleeding issues, blood clots, anemia ? _____

Type of shoe? _____Shoe Size_____