Metro Foot and Ankle – History

**Today's Date**: ____________

**Name**: ______________________________________ **DOB**:_____________________

**Chief Complaint:**____________________________________________________________________

_______________________________________________________________________________

**When did pain start?**___________________ **Type of pain: Sharp, Dull, Radiating, Other**____________________

**What makes it worse?** ___________________________________________________________________

**Home /professional treatments?**______________________________________________________

**Medical Issues**: **Circle all that apply:** Blood disorder, Heart disease, Blood clots, Hypertension, Liver disease, Kidney disease, Diabetes, Stroke, Arthritis, Gout, GI, Other: ____________________________________

**Family Medical History:** ____________________________________________________________

**Past Surgical Procedures:** __________________________________________________________

**Are you Pregnant or nursing? Y N Due Date:**_________________

**Current Medication:** _________________________________________________________________

_______________________________________________________________________________

**Drug Allergies: (Circle all that apply) None, Penicillin, Sulfa, Codeine, lidocaine, Aspirin/Motrin, Tape**
**Other:** _______________________ **describe reaction**: ______________________________________

**Are you Smoker? Y N How many daily:**_________ **Recreational Drug use? Y N Last date used?** _________

**Do you drink Alcohol? Y N How often and much?**____________

**Circle all that apply**:

**General:** fever, weight loss or gain, night sweats, loss of appetite, Other: ______________________________

**Dermatological:** rash, itch, growth or mass, hair loss, Other: _________________________________________

**GI:** heartburn, reflux, bloody stool, diarrhea, nausea, bleeding, ulceration,

Other: ______________________________________

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

Other: ______________________________________

**Neurological:** Balance issue, numbness, tingling, weakness back pain, Musculoskeletal: Joint pain, gait abnormality, autoimmune issues, bone issues, Other: ________________________________________

**ENT**: vision abnormalities, glaucoma, sore throat, thyroid, Other: ______________________________________

**Hematology:** Bleeding issues, blood clots, anemia, Other: ____________________________________________

**Please list any additional concerns**: _________________________________________________________

_______________________________________________________________________________

**Shoe Size:** ________________________________