Date _____

Foot Specialist Associates P.C.

Chart # _____

History and Physical Form

Identifying Information

Name _____ Date of Birth ___/____/____

Medical History

✔ if "Yes"

__ Liver
__ Heart Murmur
__ Blood Clot
__ Neuropathy
(specify) _____
__ Arthritis
(specify) _____
__ Alcoholism
__ Sleep Apnea
__ Stomach/Bowel
__ High Cholesterol
__ Circulation Problems
__ Gout

__ Depression
__ Allergies
__ Anxiety Disorder
__ High Blood Pressure
__ Thyroid Disease
(specify) _____
__ Musculoskeletal
__ Heart Disease
__ Mental Illness
__ Cancer
__ Diabetes (Type 1,2)
__ HIV
__ Skin Disorders

__ Breathing Issues
__ Asthma
__ Kidney Disease
__ Hepatitis
__ CVA
__ Stroke
__ Blood Disorders
Pregnant? Yes / No
Nursing? Yes / No
Other _____
_____.

Family History

✔ if "Yes" and indicate family member (blood relative)

__ Alzheimer's _____
__ Arthritis _____
__ Bleeding Disorders _____
__ Blood Clot _____
__ Cancer _____
__ Cataracts _____
__ Circulation Problems _____

__ Depression _____
__ Diabetes _____
__ Emphysema _____
__ Heart Disease _____
__ High Blood Pressure _____
__ Neurological _____
__ Strokes _____
__ Other _____

Surgical History

✔ if "Yes"

☐ 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 If yes, please describe: _____

_____

_____

_____.

Do you have any artificial joints? ☐ Yes Where? _____.

Do you have an artificial heart valve? ☐ Yes

Social History

Do you smoke? ☐ Yes If yes, how many packs per day? ____ For how long? _____

Do you drink alcohol? ☐ Yes, 5-7 days per week ☐ Yes, occasionally/socially ☐ No / Rarely

Do you currently have a substance abuse problem? ☐ Yes Specify_____

Have you had a substance abuse problem in the past? ☐ Yes Specify_____

No, I have never had a substance abuse problem: ☐

Current Occupation: _____ Does it involve mostly __ standing or __ sitting

Do you exercise regularly? ☐ Yes , and I do these exercises: _____

_____.

Review of Systems

✔ if you currently have any of these symptoms or ✔ "None

Cardiovascular
__ Leg pain when walking
__ Fainting
__ Fever
__ Palpitations
__ Chest Pain / Pressure
__ Vascular Disease
__ Leg Swelling
__ Valve Problems
__ Cold Hands/ Feet
__ None

Genitourinary
__ Blood in Urine
__ Decreased Frequency
__ Hesitancy
__ Excessive Urination
__ Incontinence
__ Kidney Disease
__ Increased Urgency
__ Kidney Stones
__ None

Gastrointestinal
__ Abdominal Pain
__ Diarrhea
__ Heartburn
__ Trouble Swallowing
__ Blood in Stool
__ Decreased Appetite
__ Ulcers
__ Increased Appetite
__ Constipation
__ Vomiting
__ None

Integumentary
__ Athletes Foot
__ Nail Abnormalities
__ Keloids
__ Itchiness
__ Dry, Scaly Skin
__ None

Hematologic
__ Lower Leg Ulcers
__ Sickle Cell Disease
__ Anemia
__ Blood Thinners
__ Clotting Disorders
__ None

Neurological
__ Tingling
__ Tremors
__ Weakness
__ Paralysis
__ Seizures
__ Numbness
__ Headaches
__ None

Musculoskeletal
__ Back Pain
__ Sciatica
__ Joint Swelling
__ Joint Stiffness
__ Joint Pain
__ Muscle Weakness
__ Joint Instability
__ Muscle Pain
__ Arthritis
__ Neck Pain
__ None

Respiratory
__ Chest Pain
__ Shortness of Breath
__ Wheezing
__ Emphysema
__ COPD
__ Coughing
__ Snoring
__ 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.

I have read all of the above: ☐ Yes

Patient Signature: _____ Date: ____/____/_____