Patient Name: Today's Date:

MEDICAL HISTORY

MAIN REASON FOR TODAY'S VISIT? (DESCRIBE LOCATION AND NATURE OF PROBLEM)

HOW LONG HAS THIS BEEN BOTHERING YOU?

WHAT TREATMENTS HAVE YOU TRIED?

ALLERGIES: Type of Reaction? Location? ☐ None ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Aspirin ☐ Tape ☐ Latex ☐ Iodine

Other Medicines, Foods: Type of Reaction? Location?	1.	2.	3.

MEDICATIONS: What medications are you currently taking? Dosage? (Include OTC, vitamins, herbs)

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

PAST MEDICAL HISTORY

Please indicate whether you have had any of the following medical conditions:

	Yes	No		Yes	No
Heart Disease/Failure	☐	☐	Arthritis	☐	☐
Heart Valve Replacement	☐	☐	Gout	☐	☐
Heart Attack	☐	☐	Fibromyalgia	☐	☐
Chest Pain/Angia	☐	☐	Osteoporosis	☐	☐
Anxiety	☐	☐	Chronic Pain	☐	☐
Coronary Artery Disease	☐	☐	Depression	☐	☐
Pacemaker	☐	☐	Leg Pain	☐	☐
High Blood Pressure	☐	☐	Back Pain	☐	☐
High Cholesterol	☐	☐	Weakness In Extremities	☐	☐
Stroke/CVA/TIA	☐	☐	Numbness In Extremities	☐	☐
Shortness Of Breath	☐	☐	Balance Problems	☐	☐
Lung Disease/ Emphysema	☐	☐	Diabetes: ☐ Type1 ☐ Type 2		
Asthma	☐	☐	Headaches/Migraines	☐	☐
Diverticulitis/Irritable Bowel	☐	☐	Gall Bladder disease	☐	☐
GERD/Heartburn	☐	☐	Seizures/Epilepsy	☐	☐
Sleep Apnea	☐	☐	Changes/Loss Of Vision	☐	☐
Liver Disease	☐	☐	Stomach Ulcer	☐	☐
Hepatitis	☐	☐	Tuberculosis	☐	☐
Rheumatologic Disease	☐	☐	Sexually transmitted disease	☐	☐
Bleeding Disorder	☐	☐	HIV/AIDS	☐	☐
Clotting Disorder	☐	☐	Cancer	☐	☐
Anemia	☐	☐	Thyroid Condition	☐	☐
DVT(Blood Clot)/PE	☐	☐	Pregnant	☐	☐
Kidney Disease/Failure	☐	☐	Dizziness	☐	☐
Raynaud's Disease	☐	☐	Peripheral Vasc. Disease	☐	☐
Neuromuscular Disorders	☐	☐	Varicose Veins	☐	☐
Arrhythmia	☐	☐	Skin Conditions:	☐	☐
Alzheimer's	☐	☐	Heart Murmur	☐	☐

Fractures (When/Where?)

Joint Replacement (Which?)

Other Condition(s)

FAMILY HISTORY

Please check if any of your family members have/had any of the following:

	Yes	No		Yes	No
Bleeding Disorder	☐	☐	Arthritis	☐	☐
Cancer	☐	☐	Bunion	☐	☐
Heart Trouble	☐	☐	Bunionette	☐	☐
High Cholesterol	☐	☐	Flat Feet	☐	☐
High Blood Pressure	☐	☐	High Arched Feet	☐	☐
Stroke	☐	☐	Pigeon-toed Feet	☐	☐
Diabetes	☐	☐	Hammertoes	☐	☐
Gout	☐	☐	Chronic ingrown nails	☐	☐

Other*(Please specify):*

SOCIAL HISTORY

	Yes	No	Details
Do you smoke?	☐	☐	# Years? __ Packs/day: __
Did you ever smoke?	☐	☐	Quit date: __ # Years? __ Packs/day __
Caffeine? *(tea /coffee)*	☐	☐	Cups per day __
Current Alcohol use?	☐	☐	#Drinks per week? __ __ Beer __ Wine __ Liquor
Past Alcohol use?	☐	☐	#Drinks per week? __ __ Beer __ Wine __ Liquor
Current or past illicit drug use/ abuse?	☐	☐	Describe:
Exercise regularly?	☐	☐	Describe:

Where Born

Occupation

Recent Travel Abroad?

Other Pertinent Social History Details

PAST SURGICAL & HOSPITALIZATION HISTORY

Procedure	**Year**	**Hospitalizations (reason)**	**Year**
1.			
2.			
3.			

HEIGHT: _____ **WEIGHT:** _____ **BP:** _____ **PULSE:** _____ **SHOE SIZE:** _____

I certify that to the best of my knowledge that the information provided is true and accurate and I have disclosed all pertinent medical history.

SIGNATURE OF PATIENT(OR GUARDIAN): _____ DATE: _____

BEVERLY HILLS FOOT & ANKLE CENTER

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