

COASTAL FOOT AND ANKLE CLINIC
Initial Patient History

Name: _____ Birthdate: ___/___/___ 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!

HISTORY OF PRESENT ILLNESS

Describe the **MAIN PROBLEM** that brings you in today: _____

Circle One: **RIGHT LEFT BOTH** How long have you had this problem? _____

Have you tried anything on your own to help this problem? _____

PRESENT MEDICAL HISTORY

Please list **ALL** medical problems/conditions (not just lower extremity): _____

Please list **ALL** medications, the dosage and frequency you take them: _____

Please list **ALL** surgeries you have had: _____

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

Please list all allergies to foods and/or medicines: _____

FAMILY HISTORY

Have any of your blood relatives had any diseases/medical problems? If so, list what relative and what problem: _____

SOCIAL HISTORY

On an average how much of the following do you have per day?

CAFFEINE: _____ TOBACCO: _____

ALCOHOL: _____

REVIEW OF SYSTEMS

Check if you have had or currently have any of the following conditions:

- | | | |
|-----------------------------------|---|--------------|
| CANCER _____, location/type _____ | MEASLES _____ | MUMPS _____ |
| SMALL POX _____ | CHICKEN POX _____ | ASTHMA _____ |
| GLASSES/CONTACTS _____ | DENTURES _____ | COPD _____ |
| PNEMONIA _____ | TUBURCULOSIS _____ | STROKE _____ |
| RESPIRATORY DISORDERS _____ | HIGH BLOOD PRESSURE _____ | HIV _____ |
| CIRCULATION PROBLEMS _____ | SCARLET FEVER _____ | GOUT _____ |
| SYPHILLIS _____ | RHEUMATIC FEVER _____ | POLIO _____ |
| ARTERY DISEASE _____ | BLEEDING DISORDER _____ | |
| PEPTIC ULCER _____ | HIATAL HERNIA _____ | |
| DIFFICULTY SWALLOWING _____ | URINARY TRACTINFECTION _____ | |
| GONORRHEA _____ | LIVER CIRRHOSIS _____ | |
| HEPATITIS _____ | LIVER DISORDERS _____ | |
| DEPRESSION _____ | HYPOTHYROID _____ | |
| HYPERTHYROID _____ | MENTAL ILLNESS _____ | |
| EPILEPSY _____ | MENINGITIS _____ | |
| NERVOUS CONDITON _____ | SPINAL DEFECT _____ | |
| BACK INJURY _____ | FRACTURES _____ | |
| DEFORMITIES _____ | BIRTH DEFECTS _____ | |
| HEART ATTACK _____ | HEART FAILURE _____ | |
| KIDNEY DISORDERS _____ | DIFFICULTY URINATING _____ | |
| RENAL STONES _____ | DIABETES MELLITUS _____ IF YES, TAKING
INSULIN _____ | |
| OTHER _____ | | |

If you need additional space to write, please use the backside of this sheet!