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Physical History Form

Name: ____

What is your foot complaint/concerns today? ____

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If you were injured, what was the date of the injury? ____

And is this injury Workman's Compensation? ____

Drug Allergies: __None or list: ____

Medications: __None or list: ____

Recent Hospitalizations/Surgeries: __None or list ____

Medical History: **Check all that apply or check none apply** ___**None Apply**

__Asthma
__Cancer/Type__________
__Diabetes 1 or 2
__Fibromyalgia
__Gout

__Heart attack
__Heart disease
__Hepatitis
__High blood pressure
__Kidney disease

__Multiple sclerosis
__Osteoarthritis
__Rheumatoid arthritis
__Parkinson's
__Stroke
__Thyroid problems

Review of Symptoms: ****Check all that apply or check none apply**** ___**None Apply**

Constitutional
__Fatigue
__Fever
__History of MRSA infection

Endocrine
__Excessive sweating
__Excessive thirst
__Heat/cold intolerance

Psychiatric
__Anxiety
__Depression
__ Memory loss

Peripheral Vascular
__Calf pain with walking
__Cold feet
__Previous bypass surgery in the legs
__Varicose veins

Musculoskeletal
__Muscle pains/cramps
__Joint Stiffness
__Backache

Neurological
__Fainting
__Numbness, burning or tingling
__Involuntary movements
__Weakness
__Seizures

Hematological/Lymphatic
__Easy bruising
__Past blood transfusion

Integumentary
__Moles or lesions
__Skin rashes
__Slow healing sores

Respiratory
__Asthma COPD__

Have you fallen in the past 12 months? __No __Yes – How many times? ______Were you injured? __________

Social History: Alcoholic drinks per week: ____ **Nicotine use:** __Never __Prior __Current – how much? _____

Physical activity level: __Inactive __Minimal __Moderate __Aggressive **Drug use/abuse:** __Yes __No

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Family History: Check and list relative (Immediate family members only i.e. Mom, Dad, Brother, Sister)

__Bleeding disorder ______________________
__Diabetes ______________________
__Heart Disease ______________________
__Stroke ______________________

___Cancer ______________________
___Drug Abuse ______________________
___High Blood Pressure ______________________
___Other ______________________ ___**None Apply**

Patient Signature: ______________________________ **Date:** ____________________