advocare | Stafford Orthopedics

Comprehensive Podiatric History Form

Today's Date: _____ Date of Birth: _____

Height: _____

Age: _____

Name: _____ Weight: _____

Occupation: _____ Shoe Size_____ Male/Female

How did you hear of us?: ___Friend ___Doctor ___Internet ___Yellow Pages Other_____

Who is the clinician requesting this consult?

Name:_____

Address:_____

Which pharmacy do you use for prescriptions?

Name:_____

Address:_____

Where is your pain or injury? Right_____ Left_____

How long have you had your pain?: _____

Is your pain/injury related to a: ___Motor Vehicle Accident ___ Work Accident ___Accident Other

Quality/Severity of pain? (check all that apply)

___Mild ___Moderate ___Severe ___Sharp ___Dull ___Achy

___Burning ___Pins/needles ___Numbness

When did you last see your primary clinician?:_____ ___I do not know ___I do not have a primary

If you are diabetic, what was your last blood sugar level? _____ When? _____

PAST MEDICAL HISTORY - Please check any of the following conditions you currently have or had in the past):

	Yes	No		Yes	No
Blood Thinners	___	___	Hypothyroidism	___	___
Lung Cancer	___	___	Neuropathy	___	___
Peripheral Vascular Disease	___	___	Colon Cancer	___	___
Kidney Disease	___	___	Foot and/or Ankle Pain	___	___
Osteoarthritis	___	___	Rheumatoid Arthritis	___	___
Hyperthyroidism	___	___	Liver Disease	___	___
MRSA	___	___	Osteoporosis	___	___
Fear or History of Falling	___	___			

PAST SURGICAL HISTORY/HOSPITALIZATIONS (check any past surgeries):

___ Neck Surgery	___ Shoulder Surgery	___ Elbow Surgery	___ Wrist Surgery
___ Hand Surgery	___ Back Surgery	___ Hip Surgery	___ Knee Surgery
___ Ankle Surgery	___ Foot Surgery	___ Shoulder Replacement	___ Hip Replacement
___ Knee Replacement	___Other		

SOCIAL HISTORY (check all that apply):

Alcohol Use	___ Every day	___ Sometimes/Social	___ Former	___ Never
Smoker:	___ Every day	___ Sometimes/Social	___ Former	___ Never

FAMILY HISTORY

Member	Alive	Deceased	Age	Health Status/Cause of Death
Father				
Mother				
Sister/Brother				
Sister/Brother				

REVIEW OF SYSTEMS:
Please check all CURRENT conditions

General:	___ Fever	___ Fatigue	___ Sleep Problems	___ Cancer	___ Weight Loss
	___ HIV	___ Night Sweats			
MS:	___ Joint Swelling	___ Cramps	___ Weakness	___Joint pain at night	___ Joint pain w/activity
Neuro:	___ Numbness	___ Tingling	___ Weakness	___ Tremors	___ Spasms
	___ Loss of balance	___ History of Seizures			
ENT:	___ Decreased Hearing	___ Sore Throat	___ Ears Ringing		
CV:	___ Chest Pain	___ Fainting	___ Stroke	___ Irregular heartbeat	___High blood pressure
	___ Blood clots	___ Phledbitis			
Resp:	___ Shortness of breath	___ Cough/asthma	___ COPD		
GI:	___ Heartburn	___ Constipation	___ Nausea	___ Vomiting	___ Diarrhea
	___ PUD	___ GERD			
GU:	___ Difficulty voiding	___ Incontinence	___ Increased frequency	___ Kidney/Bladder Infections	
Endo:	___ Weight change	___ Thirsty all the time	___ Diabetes		
Heme:	___ Easy bruising	___ Bleeding	___ Enlarged lymph nodes	___Bleeding disorder	

Any drug allergies? If yes, please list them below. If none, please write "NONE".

_____

_____

What prescription and over the counter medications are you currently taking and for how long? If none, write "NONE".

_____

_____

_____

_____

_____

FOR THE PHYSICIANS USE ONLY:

___ Well-nourished ___ Cachetic ___ increased body mass index

Doralis pedis pulses? Radial pulses? Gait is: ___ Normal ___ Antalgic ___ Ataxic

Skin: Rashes, scars, abrasions noted?

Mental Status: ___ Alert and oriented x 3. ___Confused **Sensation:** intact or diminished

Mood: ___ **A**nxious ___ Balanced