

Lansdowne Foot & Ankle Center

Patient Medical History Form

(Please Print)

Name: _____ Sex: ___M___F

Shoe Size: _____ Height: _____ Weight: _____ Age: _____

History of Present Illness:

1. What specific problem brings you to our office today? _____
2. Where is the pain/condition located? left foot/ankle right foot/ankle both
3. How long ago did this problem first start? _____
4. How would you describe the nature of your pain?
 Sharp Dull Aching Burning Radiating Itching Stabbing
 Throbbing Soreness Other: _____
5. How would you rate your pain on a scale from 0 to 10?
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)
6. What seems to make the pain/condition feel worse?
 Walking Standing Resting Dress shoes Flat Shoes Any closed shoe
 Daily activities Exercise
7. What makes condition feel better? _____
8. What treatments have you tried for this condition? _____
9. Is this problem the result of an injury? yes no
If yes, is it work related? yes no
10. Do you participate in competitive sports? yes no

Allergies:

- None
- Adhesive tape
- Iodine/shellfish
- Pennicillin
- Aspirin
- Local anesthetics
- Sulfa
- Codeine
- Demerol
- Novocaine
- Other _____

Medications: (include prescriptions, over-the-counter medications and vitamins)

Previous Surgeries: (Please list & include dates)

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Anemia	Y	N	Hepatitis or Jaundice	Y	N
Angina	Y	N	High Blood Pressure	Y	N
Arthritis	Y	N	HIV/AIDS	Y	N
Artificial Joints	Y	N	Kidney Problems	Y	N
Asthma	Y	N	Liver Disease	Y	N
Back Problems	Y	N	Low Blood Pressure	Y	N
Bleeding Disorder	Y	N	Mental Health Disorders	Y	N
Cancer	Y	N	Neuropathy	Y	N
Chest Pain	Y	N	Phlebitis	Y	N
Chronic Diarrhea	Y	N	Radiation Treatment	Y	N
Circulation Problems	Y	N	Respiratory Disease	Y	N
Diabetes	Y	N	Rheumatic Fever	Y	N
Ear Problems	Y	N	Shortness of Breath	Y	N
Epilepsy	Y	N	Sinus Problems	Y	N
Eye problems	Y	N	Skin Conditions	Y	N
Fainting or Dizzy Spells	Y	N	Slow or Non-healing wounds	Y	N
Foot and Leg Cramps	Y	N	Special Diet	Y	N
Gout	Y	N	Stroke	Y	N
Headaches	Y	N	Tuberculosis	Y	N
Heart Burn	Y	N	Ulcers	Y	N
Heart Disease	Y	N	Varicose Veins	Y	N
Hemophilia	Y	N	Venereal Disease	Y	N

Women Only		
Are you pregnant	Y	N
Breast Feeding	Y	N
Regular Menstrual Cycle	Y	N

Social:

Do you smoke? Y N

If yes what type/frequency? _____

Do you drink alcohol? Y N

If yes how much? _____

Do you use drugs? Y N

If yes what type/frequency? _____

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Review of Systems: Are you experiencing any of the following conditions?

CONSTITUTIONAL			ENDOCRINE			RESPITORY		
Nausea / Vomiting	Y	N	Hormonal problem	Y	N	Difficulty breathing	Y	N
Fever / Chills	Y	N	Excessive thirst/urination	Y	N	Shortness of breath	Y	N
Recent weight change	Y	N	Hear or cold intolerance	Y	N	Lung disease	Y	N
EYES			Dry skin	Y	N	INTEGUMENTARY		
Eye disease or injury	Y	N	Change in hat / glove size	Y	N	Edema or swelling	Y	N
Wear glasses/contacts	Y	N	GASTROINTESTINAL			Rash	Y	N
Blurred or double vision	Y	N	GI upset	Y	N	Itching	Y	N
EAR/NOSE/MOUTH/THROAT			GI or Rectal bleeding	Y	N	NEUROLOGICAL		
Hearing loss	Y	N	Abdominal pain	Y	N	Headaches	Y	N
Nose bleeds	Y	N	GENITOURINARY			Seizures	Y	N
Sore throat	Y	N	Frequent urination	Y	N	Numbness	Y	N
Sinus problems	Y	N	Burning or painful urination	Y	N	Tingling	Y	N
Difficulty swallowing	Y	N	Kidney stones	Y	N	Burning	Y	N
CARDIOVASCULAR			Female Pregnancies	Y	N	PSYCHIATRIC		
Chest pain	Y	N	Female # of miscarriages	Y	N	Anxiety	Y	N
Palpitations	Y	N	MUSCULOSKELTAL			Depression	Y	N
Heart disease	Y	N	Joint pain	Y	N	Nervousness	Y	N
Murmur	Y	N	Stiffness or swelling	Y	N	HEMATOLOGICAL		
Arrhythmia	Y	N	Low back pain	Y	N	Phlebitis	Y	N
Leg pain when walking	Y	N						

Family History: (Please list all medical conditions that may run in the family)

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Print Name of Patient, Parent or Guardian

Signature of Patient, Parent or Guardian

Date

Doctor's Signature

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Confidential Patient Information

How were you referred to us? _____

Primary Care Physician Name: _____

Date last seen by PCP: _____

Does your insurance require a referral? _____

Patient Information: (please print)

Last Name _____ First Name _____ M.I. _____

Date of Birth _____ Age _____ Sex: M F Social Sec. # _____

Marital Status (please check) Single Married Divorced Widowed

Street Address _____ City/State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

EMERGENCY CONTACT _____ PHONE #: _____

Responsible Party:

If Patient write "Self"

Policy Holder's Name _____

Address _____ City/State _____ Zip _____

Relationship to patient _____ Policy Holder's SS# _____

Date of Birth _____ Sex: M F

Insurance:

See copy of Insurance card (please check) _____

Name of Insurance Company _____

Policy Number _____ Group Number _____

Name of Secondary Insurance (if applicable) _____

Secondary Insurance Policy Number _____ Group Number _____