MEDICAL HISTORY FORM

Patient's Name: _____ Today's date: _____/_____/_____

Date of Birth: ____/____/____ Age: _____ Height: _____ Weight: _____

Primary Doctor: _____

Office location: _____

How were you referred to Silverman Ankle & Foot: ❑Primary Physician ❑Doctor ❑ER/Urgent Care ❑Podiatrist ❑Physician Assistant ❑Nurse Practitioner ❑Physical Therapist ❑Chiropractor ❑Other:_____

Name:_____ Office Address (City, State):_____

❑Internet Search ❑Health Insurance ❑Previous Patient (Name):_____

If you have litigation pending please complete the following:

Attorney and Firm Name:_____ Phone:_____

PAST HISTORY		Do you have a personal history of any of the following:(none or circle)
General	❑ **None**	Cancer Diabetes Thyroid disease Hepatitis AIDS/HIV Malignant hyperthermia
Heart/Circulation	❑ **None**	MI/Heart Attack Blood Clots High Blood Pressure Stroke Abnormal Rhythm Pacemaker Bleeding disorders Pulmonary Embolism Heart Disease
Lungs	❑ **None**	Asthma Emphysema Oxygen dependence Bronchitis Sleep Apnea
Gastrointestinal	❑ **None**	Ulcers Abdominal Surgery Crohn's Disease Reflux/GERD Inflammatory Bowel Disease
Neuro/Psych	❑ **None**	Polio Depression Seizures Chemical Dependency Psychiatric disorder Neuropathy Nerve Injury
Skin	❑ **None**	Psoriasis Delayed wound Healing Keloid(thick scars) Recurrent Cysts MRSA
Musculoskeletal	❑ **None**	Arthritis Gout Fracture Sprains/Ligament injury Previous Foot Surgery RSD/CRPS Fibromyalgia Previous Orthopedic Surgery Chronic Pain
Other		**List:**

HOSPITALIZATIONS/SURGERIES	YEAR
List all previous hospitalizations and/or surgeries.	❑ **None**

MEDICATIONS	
List any medications you are taking and why. Include herbs, inhalers, non-prescription medications.	❑ **None**

To your knowledge, have you ever taken Prednisone/Cortisone by mouth? ❑ yes ❑ no ❑ don't know

ALLERGIES	
List any medications you are sensitive to and the reaction.	❑ **None**

Have you ever had a reaction to: ❑eggs ❑shellfish/iodine ❑latex ❑rubber

FAMILY HISTORY (Grandparents, parents, siblings)					
	Father ❑ deceased	**Mother ❑ deceased**	**Brother ❑ deceased**	**Sister ❑ deceased**	**❑ Grandmother- ❑ deceased ❑ Grandfather- ❑ deceased**
Arthritis- rheumatoid, osteoarthritis	❑	❑	❑	❑	**Maternal❑ Paternal❑**
Bleeding Disorders	❑	❑	❑	❑	**Maternal❑ Paternal❑**
Blood Clots	❑	❑	❑	❑	**Maternal❑ Paternal❑**
Cancer- specify type _____	❑	❑	❑	❑	**Maternal❑ Paternal❑**
Diabetes	❑	❑	❑	❑	**Maternal❑ Paternal❑**
Difficulty with anesthesia	❑	❑	❑	❑	**Maternal❑ Paternal❑**
Heart Disease	❑	❑	❑	❑	**Maternal❑ Paternal❑**
Infectious Disease	❑	❑	❑	❑	**Maternal❑ Paternal❑**
Other: Specify_____	❑	❑	❑	❑	**Maternal❑ Paternal❑**

WORK / SOCIAL HISTORY

Marital status: ❑ Single ❑Married ❑Widowed ❑Divorced/Separated ❑Partnered Children:❑ yes❑ no How many?_____

Do you live ❑ alone ❑ with family ❑ assisted living ❑ nursing home ❑ other _____

Are you currently working? ❑ yes ❑ no **Occupation**: _____

❑Disabled: complete _____ Partial_____

Are you currently on any work restrictions? ❑ yes ❑ no If yes, what are they? _____

Do you exercise or participate in sports on a regular basis? ❑ yes ❑ no If yes, how often? _____
Type:_____

Do you use tobacco in any form? ❑yes ❑no Quit # _____years If yes, # per day_____, # of years_____

Do you drink alcohol? ❑yes ❑no If yes, # per week_____

CURRENT PROBLEMS	(check None or circle any that apply)	
General	❑ **None**	Chills/Fever Fatigue Night Sweats Recent weight loss/gain risk factors HIV/AIDS
Eyes	❑ **None**	double vision blurred vision blind spots glasses/contact lenses glaucoma cataracts legally blind dry eyes itching & redness
Ears/Nose/Throat	❑ **None**	ringing in ears difficulty hearing hearing aid deaf (read lips; ASL) frequent nose bleeds dry mouth sinus problems dentures/partial plate/braces/caps
Endocrine	❑**None**	Thyroid heat/cold intolerance difficulty sleeping dizziness excessive sweating Excessive thirst frequent urination
Respiratory/Cardio/ Hematology	❑ **None**	Chest pain chronic cough wheezing shortness of breath pneumonia coughing blood clot leg swelling leg cramps easy bruising
Gastrointestinal	❑ **None**	stomach ulcers problems with bowel movements heartburn nausea swallowing problems
Genitourinary	❑ **None**	incontinence painful urination blood in urine trouble starting stream
Reproductive	❑ **None**	pregnant possible pregnancy menopause prostate problems
Musculoskeletal	❑ **None**	joint pain joint swelling stiffness arthritis gout muscle or tendon injuries fractures childhood deformities or braces
Peripheral Vascular	❑ **None**	Varicose veins absent pulses cold extremities loss of sensation pain/cramping in legs
Skin	❑ **None**	rashes lumps sores color changes change in hair or nails skin tears easily healing issues
Neurological	❑ **None**	Balance difficulty fainting gait abnormality headache weakness memory loss seizure Tingling/numbness tremors/shaking
Psychiatric	❑ **None**	anxiety excessive stress depression eating or psychiatric disorder chemical dependency

Patient Signature: _____ Date _____

UPDATES OR CHANGES

Date	Remarks	Initial