# 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 ❑Internet ❑Print(Magazine,Add,Brochure) ❑Friend/Family ❑Work Comp/QRC ❑Word of Mouth ❑Insurance ❑Previous Patient-Name:_____ ❑Other: Name:_____ Office Address (City, State):_____

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)** | |
|---|---|---|---|
| Anxiety | COPD | Hepatitis | Osteoporosis |
| Arthritis | Depression | HIV/AIDS | Seizures |
| Asthma | Diabetes mellitus | Hypertension | Sickle cell anemia |
| Cancer | Emphysema | Kidney disease | Stroke Substance abuse |
| Cataracts | GERD | Meningitis | Thyroid disease |
| Congestive Heart Failure | Glaucoma | Myocardial infarction | Tuberculosis |
| Clotting disorder | Heart murmur | Nerve / muscle disease | Ulcers (GI) |
| | | | Other: _____ _____ |

| **PAST SURGERIES** | | Do you have surgical history of the following: (circle or list) | |
|---|---|---|---|
| Appendectomy | Small intestine surgery | Hernia repair | **Other (List):** |
| Cosmetic surgery | CABG | Valve replacement | |
| Prostate surgery | Fracture surgery | Colon surgery | |
| Brain surgery | Spine surgery | Joint replacement | |
| Eye surgery | Cholecystectomy | Vasectomy | |

**MEDICATIONS**

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

| **Medication:** | **Dose:** | **Frequency:** | **Reason:** |
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**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**

| | |
|---|---|
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**Have you ever had a reaction to:** ❑eggs ❑shellfish/iodine ❑latex ❑rubber ❑nickel ❑other: _____

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

**WORK / SOCIAL HISTORY**

Marital status: ❑ Single ❑Married ❑Widowed ❑Divorced/Separated ❑Partnered

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** | fever chills recent weight loss malaise/fatigue diaphoresis |
| Skin | ❑ **None** | rashes itching |
| Ears/Nose/Throat | ❑ **None** | hearing loss tinnitus/ringing in ears ear pain ear discharge nosebleeds congestion sinus pain stridor sore throat |
| Eyes | ❑**None** | blurred vision double vision photophobia eye pain eye discharge eye redness |
| Cardiovascular | ❑ **None** | chest pain palpitations orthopnea claudication leg swelling PND |
| Respiratory | ❑ **None** | cough hemoptysis septum production shortness of breath wheezing |
| Genitourinary/ GI | ❑ **None** | heartburn nausea vomiting diarrhea constipation blood in stool melena |
| GU | ❑ **None** | dysuria urgency frequency hematuria flank pain |
| Musculoskeletal | ❑ **None** | myalgias neck pain back pain joint pain falls |
| Endo/Heme/Aller | ❑ **None** | easy bruising/bleeding seasonal allergies polydipsia |
| Neurological | ❑ **None** | dizziness headaches tingling tremor sensory change speech change focal weakness weakness seizures loss of control |
| Psychiatric | ❑ **None** | depression suicidal thoughts substance abuse hallucinations nervous/anxious insomnia memory loss |

**Patient Signature:** _____ Date _____