ADVANCED FOOT and ANKLE SURGEONS, LLC
PATIENT MEDICAL HISTORY and SYSTEMS REVIEW

PATIENT NAME (Last, First)	Birth Date:	Today's Date:
Height:	Weight	Shoe Size

PRIMARY CARE DOCTOR

Name	
Address	
Office Phone Number	Office Fax Number

REFERRING DOCTOR or FACILITY

Name	
Address	
Office Phone Number	Office Fax Number

PREFERRED PHARMACY

Name	Address, City, State, Zip Code	Phone Number

MEDICATIONS

Medication Name	Strength	Date Started	Directions	Ordering Provider

ALLERGIES

Allergen	Reaction

PREVIOUS SURGERIES

Type of Surgery	Date Performed	Outcome

REASON FOR TODAY'S VISIT

To the best of your ability, please describe your level of pain.

☐ *Burning* ☐ *Shooting* ☐ *Sharp* ☐ *Dull* ☐ *Aching* ☐ *Throbbing* ☐ *Superficial* ☐ *Deep*
☐ *Tingling* *Other (please describe)*

How long have you had pain?

# of Days	#Weeks	#Months	#Years

How long does your pain last?

# of Seconds	#Minutes	#Hours	#Days

What makes the pain worse?

☐ *Walking* ☐ *Running* ☐ *Standing* ☐ *Sitting* ☐ *Barefoot* ☐ *Resting* ☐ *Shoes* ☐ *Other-Describe below*

Have you suffered any trauma?	No ☐	Yes ☐	When?	Describe

Describe any previous treatment and/or other information that will help us treat your condition.

Please complete both sides of this form.

SOCIAL HISTORY	
Occupation	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner
Tobacco Use	☐ **No**
	☐ **Yes** ☐ Cigarettes ☐ Cigars ☐ Other _____ Number of years you have smoked? _____ Number smoked per day _____
	☐ **Former smoker** When did you quit?
Caffeine Use	☐ **No** ☐ **Yes** Amount per day?
Alcohol Use	☐ **No** ☐ **Yes** Number of drinks per week?
Do you use drugs not prescribed for a medical condition(s)? ☐ **No** ☐ **Yes** If **Yes**, please describe:	
Do you exercise? ☐ **No** ☐ **Yes** – how often? Describe type of exercise	
HEALTH MAINTENANCE	
Date of last eye exam?	

MEDICAL SYSTEMS REVIEW: ***Please check any medical conditions that apply to you.***

General
- ☐ Recent Weight Gain
  Amount _____
- ☐ Recent Weight Loss
  Amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Nervous System
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle Spasm
- ☐ Loss of Consciousness
- ☐ Sensitivity or Pain in hands/feet
- ☐ Memory Loss

Ears
- ☐ Loss of Hearing

Eyes
- ☐ Loss of Vision
- ☐ Double or Blurred Vision

Neck
- ☐ Swollen Glands
- ☐ Tender Glands

Heart and Lungs
- ☐ Pain in Chest
- ☐ Irregular Heart Beat
- ☐ Sudden Changes in Heart Beat
- ☐ Shortness of Breath
- ☐ Difficulty Breathing at Night
- ☐ Swollen Legs or Feet
- ☐ High Blood Pressure
- ☐ Heart Murmurs
- ☐ Cough
- ☐ Coughing of Blood
- ☐ Wheezing
- ☐ Night Sweats
- ☐ High Cholesterol

Stomach and Intestines
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Vomiting of material looking like coffee grounds
- ☐ Stomach pain relieved by food or milk
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent Diarrhea
- ☐ Blood in stool
- ☐ Heartburn

Kidney / Urine / Bladder
- ☐ Difficult urination
- ☐ Frequent urination
- ☐ Pain/burning when urinating
- ☐ Blood in urine
- ☐ Cloudy/smoky urine
- ☐ Getting up at night to urinate

Blood
- ☐ Anemia
- ☐ Bleeding tendency

Skin
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Tightness
- ☐ Nodules, Bumps
- ☐ Hair loss
- ☐ Color changes of hand/feet in the cold

Muscles / Joints / Bones
- ☐ Morning stiffness, lasting _____ Min_____Hours
- ☐ Joint pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling
- ☐ List all joints affected over the past 6 months

  _____

  _____

  _____

Other Conditions
- ☐ Diabetes: Insulin dep
  Year diagnosed:_____
- ☐ Diabetes: Non-insulin dep
  Year diagnosed:_____
- ☐ Parkinson's disease
- ☐ Alzheimer's Disease