

# Ambulatory Foot Center

Podiatric Medicine and Surgery  
Adults and Children  
Foot Specialists

1619 NW Hawthorne Ave. St 110  
Grants Pass, OR 97526  
(541) 471-7056 Fax (541) 474-3201

## HISTORY AND MEDICAL INFORMATION

*Please print! Please present all your insurance cards to the receptionist to copy for our records.*

### PATIENT INFORMATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Date \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

What is your height? \_\_\_\_\_ Weight? \_\_\_\_\_ Occupation \_\_\_\_\_

Explain your foot/ankle problem \_\_\_\_\_

When did your problem begin? \_\_\_\_\_

Describe pain/discomfort:  Burning  Numbness  Sharp  Achy  Other \_\_\_\_\_

What makes pain/discomfort better? \_\_\_\_\_

What makes pain/discomfort worse? \_\_\_\_\_

Has condition been medically treated? \_\_\_\_\_ When and how? \_\_\_\_\_

### PAST MEDICAL HISTORY (check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Gout                  | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Bleeding disorders         | <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Epilepsy              |
| <input type="checkbox"/> COPD/Asthma                | <input type="checkbox"/> Cancer                | <input type="checkbox"/> High blood pressure   |
| <input type="checkbox"/> DVT (Deep vein thrombosis) | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic fever       |
| <input type="checkbox"/> High cholesterol           | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Arthritis             |
| <input type="checkbox"/> Poor circulation           | <input type="checkbox"/> Nerve disorders       | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Thyroid disorders     | <input type="checkbox"/> Depression/Anxiety    |
| <input type="checkbox"/> Joint replacement          | <input type="checkbox"/> Anticoagulant therapy | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> GI ulcers/heartburn        | <input type="checkbox"/> Kidney disease        | _____  |

### LIST ALL MEDICATIONS (including vitamins and herbs)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ALLERGIES (check all that apply)

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> None              | <input type="checkbox"/> Sulfa Drugs                | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Penicillin        | <input type="checkbox"/> Aspirin                    | _____                                |
| <input type="checkbox"/> Codeine/Narcotic  | <input type="checkbox"/> Radiographic Contrast/Dyes | _____                                |
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Shellfish                  | _____                                |

## SOCIAL HISTORY

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

Prior smoker? \_\_\_\_\_ Alcohol use (drinks per week) \_\_\_\_\_

Drug use IV, recreational? \_\_\_\_\_

Females: Are you pregnant/nursing? \_\_\_\_\_

## PRIOR SURGERIES *(include dates)*

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## FAMILY HISTORY *(list family member who has had condition)*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bleeding disorders  |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Cancer        | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Mental illness      |

Other family history \_\_\_\_\_

## CHECK IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING

### General

- Fever/Chills
- Dizziness
- Headaches
- Weight loss
- Weight gain
- Fatigue

### Eyes, Ears, Nose and Throat

- Vision problems
- Hearing problems
- Nasal congestion
- Neck stiffness

### Cardiovascular

- Chest pain
- Heart palpitations
- Leg swelling

### Respiratory

- Shortness of breath
- Cough

### Gastrointestinal

- Joint swelling/pain
- Muscle pain
- Muscle weakness
- Muscle cramps

### Skin

- Rash
- Itching

### Neurologic

- Headaches
- Paralysis
- Numbness/tingling

### Psychiatric

- Anxiety
- Depression

### Endocrine

- Frequent thirst
- Frequent urination
- Cold/heat tolerance

### Hematologic

- Tendency to bleed
- Bruise easily