History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐None ☐Appendectomy ☐ C-Section ☐Angioplasty ☐Bypass ☐Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐Yes ☐No If yes how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long?
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely
Substance abuse: ☐Yes, I have a current substance abuse problem. Please specify: _____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐leg pain when walking ☐fainting	☐fever ☐ palpitations	☐ chest pain/pressure ☐vascular disease	☐leg swelling ☐valve problems	☐cold hands/feet ☐NONE
Genitourinary	☐blood in urine ☐decreased frequency	☐hesitancy ☐excessive urination	☐incontinence ☐kidney disease	☐increased urgency ☐kidney stones	☐NONE
Gastrointestinal	☐abdominal pain ☐diarrhea	☐heartburn ☐trouble swallowing	☐blood in stool ☐decrease appetite	☐vomiting ☐ulcers ☐increase appetite	☐constipation ☐NONE
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids ☐itchiness	☐dry, scaly skin	☐NONE
Hematologic	☐lower leg ulcers	☐sickle cell disease ☐anemia	☐blood thinners	☐clotting disorders	☐NONE
Neurological	☐tingling ☐tremors	☐weakness ☐paralysis	☐seizures	☐numbness	☐headaches ☐NONE
Musculoskeletal	☐back pain ☐sciatica	☐joint swelling ☐joint stiffness	☐muscle weakness ☐joint pain ☐joint instability	☐muscle pain ☐arthritis	☐neck pain ☐NONE
Respiratory	☐chest pain ☐shortness of breath	☐wheezing ☐emphysema	☐COPD	☐coughing	☐snoring ☐NONE

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____