Podiatry Foot & Ankle Surgical Group of South FL
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7000 W. 12th Avenue, Suite 1
Hialeah, FL 33014

Medical History Form

(This form is CONFIDENTIAL)

Full Name:

Date:

Date of Birth:

Occupation:

Age: Shoe Size:

Name of Primary Care Physician:

Has he/she requested you to be seen in our office? ☐ Yes ☐ No

If not, who referred you?

Name of former Podiatrist:

Why did you see former Podiatrist?

Women only - Are you pregnant? ☐ Yes ☐ No If so, how many months?

What is your FOOT or ANKLE problem? **PLEASE BE SPECIFIC.**
Where does it hurt? How long has it been bothering you?
Is the pain sharp, dull, deep or superficial, stabbing or burning? Does it ache or tingle?
Is there any numbness? Have you had any previous treatment(s)?

List CURRENT MEDICATIONS - List dosage and why you are taking each medication.
Attach a separate list if neccessary.

1) **5)**

2) **6)**

3) **7)**

4) **8)**

List PREVIOUS SURGERY OR HOSPITALIZATIONS - Please indicate date, type & any complications.

1)

2)

3)

4)

5)

Date of last: Physical Chest X-ray
EKG Tetanus

WHO IN YOUR FAMILY HAS:

Diabetes?

Heart Disease?

High Blood Pressure?

Cancer?

Stroke?

Other Family Related Medical Problems:

HAVE YOU EVER SMOKED? ☐ Yes ☐ No

DO YOU SMOKE NOW? ☐ Yes ☐ No When did you quit?

How many packs a day? For how many years?

DO YOU DRINK ALCOHOL? ☐ Yes ☐ No

How much per day? How much per week?

LIST ALL ALLERGIES TO MEDICATIONS:

CHECK ALL THAT APPLY

Constitution:

☐ Good General Health ☐ Recent Weight Change ☐ Fever

☐ Fatigue

Eyes:

☐ Eye disease or Injury ☐ Blurred vision ☐ Double vision

☐ Glaucoma ☐ Wear glasses/contacts

Ears, nose, mouth, throat:

☐ Hearing loss ☐ Tinnitus ☐ Ear aches ☐ Sinus problems

☐ Nose bleeds ☐ Mouth sores ☐ Bleeding gums ☐ Sore throat

☐ Voice change ☐ Swollen neck glands

Cardiovascular:

☐ Hypertension ☐ Heart attack ☐ Chest pain ☐ Angina

☐ Palpitations

Respiratory:

☐ Coughs ☐ Spitting up blood ☐ Shortness of breath ☐ Asthma

Gastrointestinal:

☐ Loss of appetite or change in bowel movements ☐ Nausea
☐ Vomiting

☐ Diarrhea ☐ History of rectal bleeding ☐ Abdominal pain
☐ Heartburn

☐ History of stomach ☐ Duodenal ulcer

Musculoskeletal:

☐ Joint pain ☐ Stiffness ☐ Muscle Weakness ☐ Muscle Cramps

☐ Back pain ☐ Difficulty with walking

Integument/skin:

☐ Rash ☐ Itching ☐ Change in skin color ☐ Change in nails

Neurological:

☐ Frequent/recurring headaches ☐ Light headedness ☐ Dizziness
☐ Convulsions

☐ Seizures ☐ Numbness ☐ Tingling sensations ☐ Tremors

☐ Paralysis ☐ Stroke ☐ Head injury

Psychiatric:

☐ Memory loss ☐ Nervousness ☐ Depression ☐ Insomnia

Endocrine:

☐ Glandular problems ☐ Hormone problems ☐ Thyroid disease

☐ Diabetes ☐ Heat intolerance ☐ Cold intolerance

Hematologic/Lymphatic:

☐ Slow to heal after cuts ☐ Bleeding tendencies ☐ Anemia
☐ Phlebitis

☐ Past transfusions ☐ Enlarged glands

Immunological:

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ HIV
☐ Tuberculosis