

Indiana Podiatry Group Patient Medical History Form

Name _____ Date _____

What foot/ankle problems are you having?

Where? _____ For how long? _____

Any previous treatment? _____

Height _____ Weight _____ Shoe Size _____

Past Medical History-please circle any current or prior conditions (even if years ago)

cancer (specify) _____	back pain, hip/knee pain	asthma
high blood pressure	fractures (specify) _____	emphysema
high cholesterol	arthritis	pulmonary embolus
heart attack	sprained ankle/foot	HIV
stroke	rheumatoid arthritis	hepatitis
blood clots	fibromyalgia	rheumatic fever
poor circulation	neuromuscular disease	cellulitis or gangrene
leg/foot swelling	frequent urinary infections	blood poisoning
congestive heart failure	kidney disease or dialysis	polio
leg/foot numbness	hernia	depression
burning or tingling	heartburn/reflux	anxiety
sciatica	stomach ulcer	bipolar disorder
weakness	jaundice	developmental abnormality
seizures	pancreatitis	(specify) _____

Other Conditions _____

Past Surgical History- please list all surgeries you have EVER had, not just foot-related, as well as the approximate date performed

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Tobacco Use- Yes/No Past or current packs/day_____ Quit? How long ago_____

Alcohol Consumption- Yes/No # drinks_____per day/week/month (circle frequency)

Illicit drug use current or past_____

Family Medical History- list any history of foot problems or any major medical problems in your close relatives

Medications- list all medications, supplements, herbals, and vitamins you use, as well as what you take them for (if too many please provide a list copy)

1)_____ for _____ 7)_____ for _____

2)_____ for _____ 8)_____ for _____

3)_____ for _____ 9)_____ for _____

4)_____ for _____ 10)_____ for _____

5)_____ for _____ 11)_____ for _____

6)_____ for _____ 12)_____ for _____

What pharmacy do you use?_____ Phone#_____

Allergies- list all allergies to medicines, chemicals, metals, latex, or foods, as well as what happens when you are exposed to these products

Body System Review- list any other abnormal symptoms in your head, neck, chest, stomach/bowel, genitalia, urinary tract, joints/bones/muscles, nerves, or any other symptoms you can describe

Please tell us who your primary care physician or family doctor is_____

Any other physicians involved in your care? Please list them here, along with their specialty_____
