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)_____
diabetes
high blood pressure
high cholesterol
heart attack
stroke
blood clots
poor circulation
leg/foot swelling
congestive heart failure
leg/foot numbness
burning or tingling
sciatica
weakness
seizures

back pain, hip/knee pain
fractures (specify)_____
arthritis
sprained ankle/foot
rheumatoid arthritis
fibromyalgia
neuromuscular disease
frequent urinary infections
kidney disease or dialysis
hernia
heartburn/reflux
stomach ulcer
jaundice
pancreatitis
asthma

emphysema
pulmonary embolus
HIV
hepatitis
rheumatic fever
cellulitis or gangrene
blood poisoning
polio
depression
anxiety
bipolar disorder
developmental abnormality
(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 physcians involved in your care? Please list them here, along with their specialty_____

_____