Indiana Podiatry Group Patient Medical History Form

Name____Date____________________

What foot/ankle problems are you having?

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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

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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

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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

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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 ____

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Documentation for Flu, Pneumonia and Care Plan

INTAKE FORM

The federal government is requiring all physicians to begin collecting the information below.
This office must comply with program requirements or be penalized for non-participation.
Thank you for your corporation.

Patient's Name: _______________________________ Date of Birth: ____________________

Have you received a flu vaccination for the current year? Yes / No

If no, what was the reason? Patient Allergy / Patient Declined / Vaccine Unavailable

For Patients 65 years of age and older:

Do you have a living will or someone designated to make medical decisions on your behalf? Yes / No

Have you had a pneumonia vaccination within the past 10 years? Yes / No

For Patients with Diabetes:

Do you currently own or wear diabetic footwear? Yes / No

If yes, when did you receive your last pair? _____________

What was your most recent HgA1C (3 month blood test) result? _________________

Date of last result: _________________________