Patient's Name: ___________________________ DOB: ____________

Patient History

All information is kept confidential. If you are uncomfortable answering any questions, leave them blank. You can discuss them with your doctor.

Chief complaint (What brings you to our office today?):

____
____
____

General Medical History:

- ☐ Acid Reflux
- ☐ Alcohol/drug addiction
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder/blood clots
- ☐ Bowel problems
- ☐ Broken bones
- ☐ Cancer
- ☐ Chicken pox
- ☐ Collagen Vascular disease
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Gall bladder disease
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart disease/attacks
- ☐ Heart murmur
- ☐ Hepatitis/Liver disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Joint/back pain
- ☐ Kidney disease/stones
- ☐ Lung disease
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Seizures/epilepsy
- ☐ Sickle cell
- ☐ Stroke
- ☐ Thyroid disease – hypo/hyper
- ☐ Tuberculosis
- ☐ Ulcers/Acid Reflux
- ☐ Other: __________________________
____
____

Primary Care Physician: ____

Other Physician(s), i.e. for arthritis, diabetes, etc. _____________________________________

Patient's Name: ___________________________ DOB: ____________

Past Surgical History:

Date	Surgery

Medications (Please include any vitamins, herbs, supplements, or non-prescription drugs:

Drug Name **Dose**	**Drug Name** **Dose**

Pharmacy Name:________________________________ **Phone:**________________________

Pharmacy Address:____

Allergies: ☐None

Drug/Food/Other	**Reaction**

Social History:

Recent travel outside the U.S.? ____

Current or most recent job: ____

Marital Status: ☐Married ☐Divorced ☐Single ☐Widowed ☐Living with partner

Patient's Name: ___________________________ DOB: ____________

Smoking history: □Never smoked □Currently Smoke ______Cigarettes/Day for _____Years

□Previously smoked ______Cigarettes/Day for _____Years Quit________

Alcohol history: □Never use □Occasionally □Socially _____drinks/day _____drinks/week

Do you currently use recreational drugs?: □Yes □No What drugs?____________________

Family History:

Anyone in your family (grandparents, parents, brothers, sisters, etc.) with any medical problems:

Immunizations:

Date	Immunization	Date	Immunization
	Tetanus-Diphtheria Booster		Flu Shot
	Pneumoccocal Vaccine		Hepatitis B Vaccine
	Varicella Vaccine		Measles-Mumps-Rubella Vaccine

Review Of Systems:

Constitutional: □Change in appetite □Change in height □Difficulty sleeping □Fatigue □Fever □Weight loss □Weight gain □Night sweats □Other: ___________________________

Eyes: □Double vision □Blurred vision □Glasses/contacts □Spots before eyes □Vision changes □Other:____

Ears, Nose, Throat: □Congestion □Difficulty swallowing □Earaches/Ear infections □Hearing Problems □Mouth sores □Neck Stiffness/Pain □Nose bleeds/bleeding gums □Ringing in ears □Runny nose □Seasonal allergies □Sinus problems □Sore throat □Other:____

Cardiovascular: □Chest pain or pressure □Leg pain □Leg swelling □Rapid or irregular heart rate □ Varicose veins □Difficulty breathing with lying flat □Difficulty breathing with exertion □Other: ____

Patient's Name: ___________________________ DOB: ____________

Respiratory: □Chronic cough □Coughing up blood □Painful breathing □Shortness of breath □Wheezing □Difficulty breathing with lying flat □Difficulty breathing with exertion □Other:____

Gastrointestinal: □Abdominal pain □Acid reflux/heartburn □Black tarry stools □Bloody stools □Constipation □Diarrhea □Hemorrhoids □Incontinence □Indigestion □Jaundice □Nausea/vomiting □Other:____

Genitourinary: □Blood in urine □Frequent urination □Urinary incontinence □Frequent urinary tract infections □Pain with urination □Discoloration of urine □Other:____

Musculoskeletal: □Back pain □Joint pain □Joint stiffness □Muscle pain/cramps □Muscle weakness □Joint swelling □Redness or swelling of joints □Other:____

Skin: □Discoloration □Difficulty healing □Dry skin □Easy bruising □Itching □Moles □Open wounds/sores □Rash □Other: ____

Neurologic: □Burning □Tingling □Numbness □Dizziness □Headaches □Seizures □Tremor □Other: ____

Psychiatric: □Anxiety □Depression □Other: ____

Endocrine: □Abnormal hair growth □Abnormal thirst □Hair loss □Heat/cold intolerance □Other:____

Height:_____________ Weight: ________________ Shoe size: ________

Stonebridge Foot & Ankle
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