MEDICAL INFORMATION FORM

Patient Name ____ Account No. _________________

What are we evaluating today **Right** or **Left**; **Foot** or **Ankle** (Please circle which applies)

Date of injury or onset of pain _____________________________________

Was this a work related injury ( )Yes ( )No Current or planned legal action? ( )Yes ( )No

Describe how the accident or cause of injury occurred or what the problem is_____________________________
____
Where did this happen? ____

For each, circle what BEST applies
The pain is RARE INTERMITTENT CONSTANT
The pain is DULL SHARP ACHY THROBBING BURNING OTHER___________________

Circle ALL that apply
Your symptoms include CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS
INSTABILITY WEAKNESS TINGLING NIGHT PAIN

Have you ever experienced any injury to or symptoms involving this body part in the past? Yes ___no___

If so provide details____

Have you had any treatment for this problem?
NONE____medication____therapy____splinting____injection___surgery_____
(explain)____

Height _________Weight _________ Shoe size ______________

MEDICAL HISTORY___ No significant medical conditions (circle all that apply)
Anxiety Asthma Back Pain Bleeding disorders Coronary Artery Disease COPD
Cancer Depression Diabetes DVT Gastric reflux Glaucoma Gout
Headache Hepatitis Hypertension Heart Attack Migraine
Stroke Sleep Apnea Thyroid disorder Ulcers (gastric)
Other____

SOCIAL HISTORY
Do you use?
Tobacco none ____previous _____last used ______current _____packs/day_________
Alcohol none ____occasionally ____ daily___
Recreational Drug use none____ previous _____current ______last used_______
Substance abuse______

SURGICAL HISTORY: ___NONE (circle all that apply)
Appendectomy Breast Augmentation CABG Cataract Cesarean Section
Cholecystectomy Fracture repair Gastric banding/bypass Hernia repair
Hysterectomy Joint replacement Knee surgery Lasik
Pace Maker Shoulder surgery Tonsillectomy Spine Surgery
Foot or Ankle Other____

Anesthesia Complications? ____

FAMILY HISTORY______ No significant Family History (circle all that apply)
Bleeding Disorders   Heart Disease   DVT/PE   Hypertension   Hemophilia
Malignant Hyperthermia   Stroke   Von Willebrand disease
Other______________________________________

Known Allergies (Include Medications) **None**: ________

Medication	Reaction

Medications: List all medications that you take regularly or frequently (include frequency of use, strength and dosage) **None**: _____

Preferred pharmacy	Name	Phone number
Medication	Dose (milligram)	Frequency

Other Current medical symptoms (circle all that apply) None: _______
CONSTITUTIONAL: Fever Chills Weakness Fatigue
HEAD: Dizziness Fainting Pain Headaches
EYES: Blurred Vision Discharge Double vision Eye pain Redness Vision Loss
ENT: Hay Fever Bleeding gums Loss of hearing Ringing of ears Enlarged nodes
RESPIRATORY: Cough Wheezing Shortness of breath Pain
CARDIOVASCULAR: Chest Pain Palpitations Cold extremities Pain with walking
GASTROINTESTINAL: Constipation Diarrhea Heartburn Bloody stool Nausea/vomiting
MUSCULOSKELETAL: Joint Pain Joint stiffness Muscle cramps Weakness Paralysis
PSYCHIATRIC: Depression Behavioral changes Memory loss Nervousness
SKIN: Itching Dryness Skin lumps Change in color Rash
NEUROLOGIC: Headaches Memory loss Numbness Tingling Gait change
ENDOCRINE: Change in weight Cold intolerance Excessive urination Thirst Sweats
HEMATOLOGIC: Easy bleeding Blood clots Easy bruising
GENITOURNIARY: Blood in urine Flank Pain Incontinence Kidney stones

If yes to any of the above questions, please explain: ____
____
____

Patient Signature: X____ **Date:** _______________

Physician's Signature: X____ **Date:** _______________