

**KBF FOOT AND ANKLE SURGEONS, PA  
PATIENT MEDICAL HISTORY**

**GENERAL INFORMATION**

Name: Mr., Mrs., Ms, Dr.		Age:	Birth Date:
Primary Care Physician			Last Date Seen:
Referring Physician / Source		Pharmacy Name, Address, Phone	
Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Height:	Weight:	Shoe size:
<b>Explain your foot /ankle problem:</b> <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Ankle <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Ankle			

When did the pain begin (date)? \_\_\_\_\_ On a scale of 1 – 10, please rate your pain: \_\_\_\_\_

Describe your pain:  Sharp  Dull ache  Burning  Throbbing  Shooting  Other: \_\_\_\_\_

What treatments have you tried? \_\_\_\_\_

What makes your pain/discomfort feel better: \_\_\_\_\_

Is your problem work related:  Yes  No Have you had a physical trauma?  Yes  No

<b>Past Medical History:</b> <input type="checkbox"/> None <input type="checkbox"/> Allergies <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Back Pain <input type="checkbox"/> Blood Clots <input type="checkbox"/> Cancer <input type="checkbox"/> Circulation <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> GERD/Gastritis <input type="checkbox"/> Gout	<input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Joint Replacement <input type="checkbox"/> kidney disease/Failure <input type="checkbox"/> Lyme disease <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Stroke <input type="checkbox"/> TB <input type="checkbox"/> Thyroid Disease	<b>Family History? List relationship of family member(s)</b> Alcoholism Arthritis Asthma Breast Cancer Cancer Diabetes Heart Disease Hypertension High Cholesterol Kidney Disease Stroke Other Family History: _____
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Other medical history we should be aware of: \_\_\_\_\_

Are you currently pregnant?  No  Yes How many weeks? \_\_\_\_\_

**Social History:**  
 Tobacco Use:  Current every day smoker  Current some day smoker  Former Smoker  Never  
 How much? \_\_\_\_\_ How Long? \_\_\_\_\_  
 Alcohol Use:  Social  Occasional  Never  Daily  
 Drug Use (recreational)  Never  Yes  
 Do you Exercise?  No  Yes If yes, how often? \_\_\_\_\_

**Surgical History:**  None  
 Surgery/Date: \_\_\_\_\_  
 Surgery/Date: \_\_\_\_\_  
 Surgery/Date: \_\_\_\_\_

**Medications:** Please list the medications you have taken in last 6 months

Drug Name	Dosage	Drug Name	Dosage
1)		4)	
2)		5)	
3)		6)	

<b>Allergies: Describe reaction</b>			
<input type="checkbox"/> NONE	<input type="checkbox"/> Anesthesia/Novocain	<input type="checkbox"/> Aspirin	
<input type="checkbox"/> Bee Sting	<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex	
<input type="checkbox"/> Narcotic/Codeine	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Radiographic Dye	
<input type="checkbox"/> Shellfish	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Other	
<b>REVIEW OF SYSTEMS Please check all that applies; Please add if not listed.</b>			
<b>Cardiovascular</b>			
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Mitral valve prolapse
<input type="checkbox"/> Swelling	<input type="checkbox"/> Leg Pain with exercise	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Blood Clots
<b>Head, Ears, Nose, and Throat</b>			
<input type="checkbox"/> Dentures	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Other
<b>Respiratory</b>			
<input type="checkbox"/> COPD	<input type="checkbox"/> Cough	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Exposure to TB
<input type="checkbox"/> Pulmonary Disease	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Wheezing	
<b>Gastrointestinal</b>			
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Decrease in Appetite
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting		
<b>Genitourinary</b>			
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Frequency	
<b>Musculoskeletal</b>			
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gait problems	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Prior Fracture			
<b>Skin</b>			
<input type="checkbox"/> Color Change	<input type="checkbox"/> Cracking	<input type="checkbox"/> Eczema	<input type="checkbox"/> Dry Skin
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Infections	<input type="checkbox"/> Lesions	<input type="checkbox"/> Rash
<input type="checkbox"/> Slow Healing	<input type="checkbox"/> Sun Sensitivity	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Fungal toenail
<b>Nervous System</b>			
<input type="checkbox"/> Confusion	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Fainting	<input type="checkbox"/> Headache
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Speech Difficulties	<input type="checkbox"/> Stroke	<input type="checkbox"/> Walking problems
<b>Constitutional</b>			
<input type="checkbox"/> Chills	<input type="checkbox"/> Fever	<input type="checkbox"/> Sweats	<input type="checkbox"/> Weight Change
<b>Endocrine</b>			
<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Often Thirsty	<input type="checkbox"/> Prior Kidney Disease	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Urinary Symptoms		
<b>Hematologic/Lymphatic</b>			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding Problem	<input type="checkbox"/> Lymphoma	
<input type="checkbox"/> Skin lump	<input type="checkbox"/> Swollen Glands		
<b>Allergic, Immunologic History</b>			
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Lupus	<input type="checkbox"/> Collagen Vascular
<b>Eyes</b>			
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Eyeglasses
<b>Psychiatric</b>			
<input type="checkbox"/> ADHD	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Panic Attack
I hereby give my permission to Drs. Blicht, Fritz, and staff to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my foot and / or ankle disorder.			
_____ <b>Signature of Patient or Guardian</b>		_____ <b>Patient's Name (print)</b>	
		_____ <b>Date</b>	