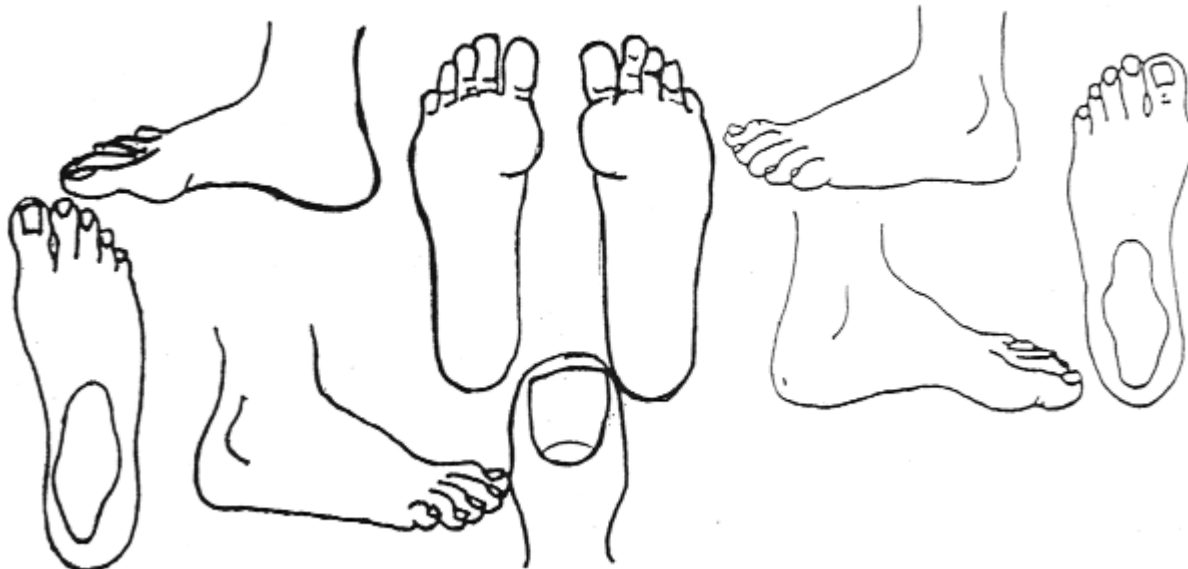


The Spine & Orthopedic Center
PATIENT MEDICAL HISTORY
 James Kinchsular, DPM
 (Please Print Clearly)

Today's date:		PCP:		Translator:		
PATIENT INFORMATION						
Patient's last name:		First name (middle initial):		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	
Marital status (circle one) Single / Mar / Div / Sep / Wid						
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age: 	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F						
Race:		Height:		Weight:		
Shoe Size:						
Occupation:		Employer:			Employer phone no.: ()	
Referred to clinic by (please check one box): <input type="checkbox"/> Dr.				<input type="checkbox"/> Insurance Plan		
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Hospital		
<input type="checkbox"/> Other						

Please indicate where you feel pain on the foot and ankle diagram below.



RIGHT

LEFT

Chief Concern/History of Present Concern

Current foot or ankle problem:

Nature (Sharp, Dull, Achy, Burning, etc.):

Location (Where is the pain?):

Duration (How long have you had the problem?):

Onset (What happened? New Activities, New Shoes, New Job, Accident, etc?):

Course (Intermittent, Constant, Progressive):

Aggravates (What makes the pain worse? Standing, Sitting, Not Wearing Shoes, Climbing, etc?):

Treatment (What has been done and did it help?):

Medical History: Do you or have you had any of the following medical conditions:

Condition	Yes	No
Acne		
Anemia/Sickle Cell		
Arthritis		
Artificial Joint Replacement		
Asthma/Bronchitis		
Basal Cell		
Bleeding Disorders		
Cancer (any type)		
Cataracts		
Charcot Foot		
Charcot Marie Tooth		
Diverticulitis		
Epilepsy/Seizures		
Fibromyalgia		
GI Bleeding/Ulcers		
GI Reflux		
Gout		
Heart Disease/Heart Attack		
Hepatitis A, B or C		
Hernia		
High Blood Pressure		

Condition	Yes	No
Hyperthyroid		
Hypothyroid		
Immune Disease (HIV, AIDS)		
Insulin Dependent Diabetes Mellitus		
Kidney or Bladder		
Liver Disease		
Malignant Melanoma		
Melanoma		
Mitral Valve Prolapse		
Muscular Dystrophy or other Neuromuscular Disorders		
Non-Insulin Dependent Diabetes Mellitus		
Pulmonary Fibrosis		
PVD		
Raynaud's Disease		
Rheumatoid Arthritis		
RSD		
Rosacea		
Squamous Cell		
Stroke		
Thyroid Disease		
Warts		

List any other medical problems not listed above:

Surgeries and Hospitalizations: (Describe procedure and any complications.)

Date	Surgery

Medications: Please list ALL medications you are currently taking (including non-prescription drugs, vitamins, and supplements):

Name	Dose	How often?

Allergies - please indicate all known allergies and type of reaction that occurred. (aspirin, sulfa drugs, penicillin, iodine, Novocain, tape, foods, drugs, etc.)

Name	Reaction

Have you ever had a reaction to local or general anesthesia? Yes No

Family History: List all medical problems your parents have/had, such as high blood pressure, diabetes, cancer, bunions, flatfeet, hammertoe, poor circulation, etc.

Mother:	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Condition:
Father:	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Condition:
Name of Family Physician:	Date Last Seen (approx.):	
Name of Former Podiatrist:	Date Last Seen (approx.):	

Social History: Please check all that apply.

Occupation:		
How do you spend most of your time? (Standing, Walking, Heavy lifting, etc.):		
Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List any sports or exercise you do:		
Do you smoke tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much?	What kind?
Do you drink caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much?	What kind?
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much?	What kind?
Do you do illicit drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much?	What kind?
Additional comments/concerns?		

Review of Systems: Please check all that apply over the last 3 months time.

General		
Symptom	Yes	No
Nausea		
Vomiting		
Fever		
Chills		
Loss of Appetite		
Malaise		

HEENT		
Symptom	Yes	No
Headaches/Migraines		
Visual Changes		
Ringing in Ears		
Hearing Loss		
Runny Nose		
Sore Throat		
Swallowing Difficulty		

Neuro/MSK		
Symptom	Yes	No
Muscle Weakness		
Joint Pain, Redness, Swelling		
Muscle Spasms/Cramping		
Low Back Pain		
Numbness/Tingling		
Sudden Loss of Function		

Lungs/Chest		
Symptom	Yes	No
Cough		
Coughing Blood		
Shortness of Breath at Rest		
Wheezing		
Chest Pain/Angina		
Orthopnea (difficulty breathing laying flat)		
Calf Cramping when Walking		
Leg Swelling/Edema		

GI/GU		
Symptom	Yes	No
Diarrhea		
Constipation		
Blood in Stool		
Incontinence (bowel/urinary)		
Pain with Urination		
Blood in Urine		
Pus in Urine		
Urinary Retention		
Urinary Frequency		

Endocrine		
Symptom	Yes	No
Hot or Cold Spells		
Recent Weight Change		
Change in Appetite and Thirst		

Skin		
Symptom	Yes	No
Sores (new or non-healing)		
Rash		
Itching		
New Lesions		

Briefly explain all items you answered "yes" to above:

Additional Comments:

Please provide any additional comments or concerns that you feel are important regarding your foot and ankle problem not adequately addressed above.

I hereby give The Spine and Orthopedic Center Specialists permission to diagnose and administer treatment for my foot and ankle condition and authorize any release of information obtained in the course of my treatment.

Signature: _____ Date: _____