Reconstructive Foot & Ankle Specialists, LLC
7920 W. Jefferson Blvd. Suite 230
Fort Wayne, IN 46804

MEDICAL HISTORY

PATIENT NAME:____DATE____________________

FAMILY PHYSICIAN:_________________________REFERRING PHYSICIAN ;___________________

DATE OF BIRTH___________________AGE_____________HEIGHT_________WEIGHT_________

OCCUPATION:____SHOE SIZE_________

HISTORY OF PRESENT ILLNESS

Describe your problem or reason for your visit:____

Is this the result of an injury? YES / NO If yes, date of injury?______________________________

How did the injury occur?_____________________________Location where injury occurred?___________

EVALUATION OF PAIN / DISCOMFORT

What body part is affected?__________________________When did the problem start?_______________

When does the problem occur?_______________________How long does it last?____________________

What makes it feel better?______________________What makes it feel worse?______________________

CIRCLE ONE MILD MODERATE SEVERE

PAIN SCALE 1 2 3 4 5 6 7 8 9 10

What activities are you unable to do because of pain?________________________________

PREVIOUS TREATMENT FOR THIS PROBLEM

Diagnostic Testing: X-RAY CT MRI EMG OTHER_________

Medications:____

Physical Therapy / Location:____

Other treatment for this condition:____________________ Other Doctors treating this______________

Is this condition being covered by Worker's Compensation? YES / NO Last date worked:________

PAST MEDICAL HISTORY (circle all that apply))

Diabetes	Parkinson's Disease	Hepatitis	Bladder Disease	High Blood Pressure
Multiple Sclerosis	Stomach Ulcers	Skin Disorder	Thyroid (Hypo/Hyper)	Heart Disease
Gastrointestinal Disease	Bleeding Disorder	Parathyroid	Heart Attack	Liver Disease
Rheumatoid Arthritis	Tuberculosis	Irregular Heart Beat		Prostate
Osteoarthritis	Stroke	Asthma	Kidney Disease	Gout
Seizure Disorder	Bronchitis	Vascular Disease		Osteoporosis
AIDS / HIV	Current or Recent Pregnancy		Cancer	High Cholesterol

Other Describe:____

ALL PREVIOUS SURGERIES

Description____________________Date__________Description___________________Date__________

Description____________________Date__________Description___________________Date__________

Description____________________Date__________Description___________________Date__________

MEDICATIONS

Name of Medication	Dose	How Often	Name of Medication	Dose	How Often

ALLERGIES

Drug			Other Latex Y / N

FAMILY HISTORY (Circle all that apply)

Bleeding Disorder	Cancer	Diabetes
Malignant Hyperthermia	Musculoskeletal Disease	Heart Disease
Osteoporosis	Other____________	Non-contributory

SOCIAL HISTORY (Circle all that apply)

Married Single Divorced Widow / Widower Separated

Tobacco Pks/day:_____ / None Alcohol Frequency:________/ None

Illicit / Illegal Drug use: Frequency:__________ / None

REVIEW OF SYSTEMS (check all that apply)

Constitutional ☐ Normal
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night sweats

Integumentary ☐ Normal
- ☐ Rashes
- ☐ Birthmarks
- ☐ Open wounds or sores
- ☐ Drainage

Musculoskeletal ☐ Normal
- ☐ Multiple joint pain
- ☐ Multiple joint swelling
- ☐ Multiple joint stiffness
- ☐ Generalized muscle weakness
- ☐ Deformity

ENTM ☐ Normal
- ☐ Frequency of unusual headache
- ☐ Hearing loss
- ☐ Mouth or dental infections

Eyes ☐ Normal
- ☐ Loss of vision

Respiratory ☐ Normal
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Productive cough

Cardiovascular ☐ Normal
- ☐ Chest pain or pressure
- ☐ Irregular heart beat
- ☐ Swelling of ankles
- ☐ Blood clots in legs or lungs
- ☐ Varicose veins

Hematologic ☐ Normal
- ☐ Bleeding Disorders

Gastrointestinal ☐ Normal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea-Chronic

Genitourinary ☐ Normal
- ☐ Incontinence
- ☐ Frequency of urine
- ☐ Urgency of urine
- ☐ Retention of urine

Neurological ☐ Normal
- ☐ Paralysis
- ☐ Loss of sensation

Psychiatric ☐ Normal
- ☐ Depression
- ☐ Episodes of mania
- ☐ Inability to sleep

Endocrine ☐ Normal
- ☐ Diabetes
- ☐ Thyroid Disorder

I certify that the the above information is true and current to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and /or treatment of my feet and ankles.

Signature____ Date____________________________________