The Metropolitan Foot & Ankle Group

(a D/B/A of Michael H. Loshigian DPM PC)

Patient Health History Questionnaire

Last Name:_____ **First Name:**_____ **Date of Birth:**_____

Past Medical History

- ☐ Acid Reflux
- ☐ Alzheimer's Disease
- ☐ Angina
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots / DVT
- ☐ Cancer_____
- ☐ High Cholesterol
- ☐ Chemical Dependency
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease/IBS
- ☐ Diabetes – Type ____
- ☐ Emphysema/COPD
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Herpes Zoster
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ HIV or AIDS
- ☐ Kidney Problems

☐ **NO Past Medical History**

- ☐ Low Blood Pressure
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Lupus
- ☐ Mental Illness
- ☐ Morbid Obesity
- ☐ Neuropathy
- ☐ Phlebitis
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Swollen Glands
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Weight Loss
- ☐ Other_____

Past Podiatric Medical History

- ☐ Ankle or Foot pain
- ☐ Athlete's Foot
- ☐ Arthritis
- ☐ Bunions
- ☐ Bursitis
- ☐ Cerebral Palsy
- ☐ Corns/Calluses
- ☐ Cellulitis/Infection
- ☐ Dislocations_____
- ☐ Fibromyalgia
- ☐ Flat Feet
- ☐ Fractures_____
- ☐ Foot or Leg Cramps
- ☐ Ganglion Cyst
- ☐ Heel Pain
- ☐ Heel Spur

☐ **NO Past Podiatric Medical History**

- ☐ Herniated Disc
- ☐ Ingrown Toenails
- ☐ Multiple Sclerosis
- ☐ Neuroma
- ☐ Numbness in Feet
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pain – Back
- ☐ Pain – Knee
- ☐ Psoriatic Arthritis
- ☐ Plantar Warts
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Sprains/Strains____
- ☐ Swelling of Joints
- ☐ Tarsal Tunnel Syndrome

Past Surgical History

☐ **NO Past Surgical History**

Surgery(ies) you have had in the past:_____

_____

_____

Family History

☐ **NO Family History**

- ☐ Alcoholism
- ☐ Stroke
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Gout
- ☐ Hypertension
- ☐ Mental Illness
- ☐ Other_____

Work Status: ☐ Disabled ☐ Homemaker ☐ On Leave ☐ Retired ☐ Student ☐ Unemployed ☐ Working

Alcohol use? ☐ No Alcohol ☐ Yes, consume alcohol (___ drinks per day) ☐ Social Drinker

Tobacco use? ☐ Never ☐ Current everyday ☐ Current occasional ☐ Formerly (Quit _____ years ago)

Recreational drug use?: ☐ Never ☐ Currently ☐ In the Past

Are you Pregnant? ☐ Yes ☐ No

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Patient Name:_____

Do you have any Drug Allergies?:

☐ Adhesive/Tape ☐ Aspirin ☐ Blood Thinners ☐ Codeine ☐ Iodine ☐ Local Anesthetics
☐ Penicillin ☐ Shellfish ☐ Sulfa ☐ Other_____

Are you currently taking any medications?_____

_____

_____

Chief Complaint: What is the main reason for your visit today? Describe the problem in detail. (What Hurts?)

_____

_____

_____

Side: ☐ Left ☐ Right ☐ Both **Area with most pain?** ☐ Toes ☐ Top of Foot ☐ Bottom of Foot ☐ Ankle

How long have you had pain? Weeks____ Months____ Years____ **Date of Injury**(if applicable):_____

Is this injury: ☐ Work related? ☐ Motor Vehicle Accident related? ☐ Sports related? ☐ Trauma related?

What is your pain quality? ☐ Dull ☐ Sharp ☐ Achy ☐ Burning ☐ Stabbing ☐ Tingling ☐ Soreness

When is pain the worst? ☐ Morning ☐ Evening ☐ After Activity ☐ At Night (interferes with sleep)

Pain Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What actions/activities make the problem worse?

☐ Walking ☐ Standing ☐ Running ☐ Bending ☐ Lifting ☐ Reaching ☐ Driving ☐ Sitting
☐ Other:_____

What actions/activities make the problem better?

☐ Resting ☐ Ice ☐ Heat ☐ Elevation ☐ Pain Meds ☐ Activity ☐ Other_____

Are there any other associated signs or symptoms?

☐ Weakness ☐ Numbness/Tingling ☐ Radiating Pain ☐ Instability

Have you had any diagnostic studies or treatments for this problem? If so, when and where?

☐ X-Ray ☐ MRI ☐ EMG/NCV ☐ CT ☐ Ultrasound ☐ Physical Therapy ☐ Injections ☐ Bracing
☐ Surgery_____ ☐ Other_____

Are there any specific treatment options that brought you to us?

(i.e. Stem Cell, Visco-supplementation, PRP, Laser Treatment, Orthotics, etc…)

_____

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Patient Name:_____

REVIEW OF SYSTEMS

Please check any symptoms that you are currently experiencing.

☐ NONE of the below

Constitutional: ☐ Chills ☐ Fever ☐ Headache ☐ Weight Gain/Loss ☐ Fatigue ☐ Body Ache

Cardiovascular: ☐ Chest Pain ☐ Hypertension ☐ Palpitations ☐ Varicosities ☐ Rapid Heart Rate

Genitourinary: ☐ Urine Hesitancy ☐ Incontinence ☐ Urinary Retention ☐ Hematuria

Musculoskeletal: ☐ Back Pain ☐ Joint Swelling ☐ Joint Pain ☐ Neck Pain ☐ Ankle Instability
☐ Joint Stiffness ☐ Muscle Cramps ☐ Leg Cramps ☐ Muscle Weakness

Hema-Lymph: ☐ Anemia ☐ Blood Clotting ☐ Swollen Glands ☐ Easy Bruising

HEENT: ☐ Sore Throat ☐ Ear Infection ☐ Nasal Congestion ☐ Nose Bleeding ☐ Blurred Vision

Respiratory: ☐ Shortness of Breath ☐ Wheezing ☐ Cough

Gastrointestinal: ☐ Abdominal Pain ☐ Constipation ☐ Jaundice ☐ Diarrhea ☐ Nausea/Vomiting ☐ Ulcers

Integumentary: ☐ Boils ☐ Itching ☐ Redness ☐ Skin Rash ☐ Open Wound

Neurologic: ☐ Blackouts ☐ Dizziness ☐ Tingling/Numbness ☐ Seizures ☐ Tremors ☐ Sciatica

Endocrine: ☐ Excessive Thirst ☐ Tired ☐ Too Cold/Hot

Psychiatric: ☐ Depression ☐ Difficulty Sleeping ☐ Anxiety

Allergic/Immunologic: ☐ Drug Allergies ☐ Hay Fever ☐ Runny Nose

FOR OFFICE USE ONLY:

Treatment Consent: I hereby consent and give my permission to the doctor (and doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Name of Patient:_____ Date:_____

Signature of Patient/Guardian:_____ Relation to Patient:_____