

# Personal Health History

Family Physician \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

What problem brings you to the office? \_\_\_\_\_ Pain scale at worst(1-10) \_\_\_\_\_

How long has this bothered you? \_\_\_\_\_ Have you tried self treatments/home remedies? \_\_\_\_\_

How is your general health?  Good  Fair  Poor

Do you have diabetes?  yes  no  borderline Last blood sugar \_\_\_\_\_

Is there a family history of :  Diabetes  Tuberculosis  Cancer

What medications are you taking? \_\_\_\_\_

Are you taking : Blood thinners \_\_\_\_\_ Cholesterol Medicine \_\_\_\_\_ Thyroid Medicine \_\_\_\_\_

What vitamins or supplements are you taking ? \_\_\_\_\_

List any operations you have had: \_\_\_\_\_

1. Have you had any of the following:

YES  NO  Alcohol addiction

YES  NO  Alzheimer's

YES  NO  Anemia

YES  NO  Arthritis

YES  NO  Asthma

YES  NO  Blood Disease

YES  NO  Blood Transfusion

YES  NO  Broken Bones

YES  NO  Burning in feet/legs

YES  NO  Cancer

YES  NO  Circulation Disease

YES  NO  Drug Addiction/treatment

YES  NO  Epilepsy

YES  NO  Hardening of the arteries

YES  NO  Heart Trouble

YES  NO  Hepatitis

YES  NO  High Blood Pressure

YES  NO  Illicit Drug use

YES  NO  Kidney Trouble

YES  NO  Liver Trouble

YES  NO  Numbness in Feet/legs

YES  NO  Parkinson's

YES  NO  Phlebitis

YES  NO  Polio

YES  NO  Prolonged Bleeding

YES  NO  Raynaud's Disease

YES  NO  Rheumatic Fever

YES  NO  Stomach Ulcers

YES  NO  Swelling in feet/legs

YES  NO  Tingling in feet/legs

YES  NO  Tuberculosis

YES  NO  Varicose Veins

**Are you allergic to the following:**

Adhesive Tape

Anesthetics

Drugs \_\_\_\_\_

Erythromycin

Foods \_\_\_\_\_

Novocaine

Penicillin

Sulfa

Other \_\_\_\_\_

Do you use alcohol? \_\_\_\_\_

How often? \_\_\_\_\_

Are You Smoker ? \_\_\_\_\_

How many packs a day? \_\_\_\_\_

\_\_\_\_\_

Pregnant? \_\_\_\_\_

Do you take birth control pills? \_\_\_\_\_

History of stroke or heart attack? \_\_\_\_\_

Do you spend more than 50% of your workday standing? YES  NO

The information provided above is true and accurate to your best knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dr. Initial: \_\_\_\_\_

# FOOT AND ANKLE HEALTH CENTER

## PAIN SCALE

PLEASE INDICATE THE LEVEL OF PAIN YOU ARE HAVING ON THE SCALE BELOW. "0" MEANS NO PAIN AND "10" MEANS THE WORST PAIN.



LEFT FOOT



I-----I-----I-----I-----I-----I-----I-----I-----I-----I-----I  
0 1 2 3 4 5 6 7 8 9 10



RIGHT FOOT



I-----I-----I-----I-----I-----I-----I-----I-----I-----I-----I  
0 1 2 3 4 5 6 7 8 9 10

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Cell# ( ) \_\_\_\_\_ SS# \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Who do we contact in an emergency : \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Married: \_\_\_\_\_ Single: \_\_\_\_\_ Widowed: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_

Spouse/Parent/Guardian: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insured SS#: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Address of Employer: \_\_\_\_\_ City \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Patient Signature/Guardian \_\_\_\_\_ Date \_\_\_\_\_