CENTER FOR FOOT & ANKLE SURGERY, LLC

HEALTH HISTORY

Patient Name _____ **Date**_____

Chief Complaint _____

History of Present Illness:

Location: _____
(Where is the pain/problem)

Quality: _____
(Example: normal versus abnormal color, activity etc.)

Severity: _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the worst?)

Duration: _____
(How long have you had this pain/problem? Or when did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this problem?)

Associated signs/symptoms: _____
(What other associated problems have you been having?)

Modifying factors: _____
(What makes the pain/problem worse/better?)

PAST MEDICAL HISTORY

Have you ever had the following: (Circle "no" or "yes" or leave blank if uncertain)

Measles	No Yes	Anemia	No Yes	Back trouble	No Yes	Ulcer	No Yes
Mumps	No Yes	Bladder infections	No Yes	High blood pressure	No Yes	Kidney Disease	No Yes
Chickenpox	No Yes	Epilepsy	No Yes	Low blood pressure	No Yes	Thyroid Disease	No Yes
Whooping Cough	No Yes	Migraine headaches	No Yes	Hemorrhoids	No Yes	Bleeding Tendency	No Yes
Scarlet Fever	No Yes	Tuberculosis	No Yes	Asthma	No Yes	Any other disease?	No Yes
Diptheria	No Yee	Diabetes	No Yes	Hives or Eczema	No Yes	Please list:	
Smallpox	No Yes	Cancer	No Yes	AIDS or HIV+	No Yes		
Pneumonia	No Yes	Polio	No Yes	Infectious Mono	No Yes	_____	
Rheumatic Fever	No Yes	Glaucoma	No Yes	Bronchitis	No Yes		
Heart Disease	No Yes	Hernia	No Yes	Mitral Valve Prolapse	No Yes	_____	
Arthritis	No Yes	Blood or Plasma		Stroke	No Yes	Date of last chest	
Venereal Disease	No Yes	transfusions	No Yes	Hepatitis	No Yes	x-ray:	
						_____	

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES	**WHEN?**	**HOSPITAL, CITY, STATE**
_____	_____	_____
_____	_____	_____

MEDICATIONS: (include non-prescription)_____

PATIENT SOCIAL HISTORY:

Marital status: Single _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of alcohol: Never _____ Rarely _____ Moderate _____ Daily _____
Use of tobacco: Never _____ Previously but quit _____ Yes, current packs per day _____
Use of drugs: Never _____ Yes/type/frequency _____
Excessive exposure at home or work to: Fumes: _____ Dust _____ Solvents _____ Airborne particles _____ Noise _____

FAMILY MEDICAL HISTORY:

	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____