Foot & Ankle Clinic of Spokane/ Idaho

CURRENT MEDICAL HISTORY

Last Name: Legal First Name: MI:

DOB: Age: _____ Gender: ❑ Male ❑ Female Weight: Height: _____ Shoe Size: _____

❑ PCP or ▫ Referring Physician: Phone: Date Last Seen:

Reason for Visit with Us: Date Occurred:

Is Your Condition: ❑ **None** ❑ Work Related ❑ Due to an Automobile Accident ❑ Due to a liability claim

Current Problem

Location: ❑ Bottom of ❑ In between ❑ Inside of foot ❑ Left ❑ Right ❑ Top of ❑ Other:

Site: ❑ Ankle ❑ Arch ❑ Ball of foot ❑ Calf ❑ Foot ❑ Heel ▫ Leg ▫ Toe(s) ▫ Other:

Started: ❑ Today ❑ #_____Days ❑ #_____Weeks ❑ #_____Months ❑ #_____Years

How often: ❑ At night ❑ Constant ❑ In AM ❑ Off and on ❑ Rare ▫ Recurrent ▫ Other:

Feels like: ❑ Aching ❑ Bruised ❑ Burning ❑ Cramping ❑ Deep ❑ Dull ❑ Improving ❑ Inflamed ❑ Itchy ❑ Tight ❑ Tingling ❑ Other:

Pain scale: (Circle) 0 1 2 3 4 5 6 7 8 9 10 –worst ❑ Improving ❑ Resolved ❑ Unbearable ❑ Unchanged

Caused by: ❑ Barefoot ❑ Fell ❑ Increased activity ❑ Injury ❑ Running ❑ Unknown ❑ Other:

Better with: ❑ Compression ❑ Elevation ❑ Heat ❑ Ice ❑ In shoes ❑ Medication ❑ Rest ❑ Other:

Worse with: ❑ Increased activity ❑ In shoes ❑ No shoes ❑ Pressure ❑ Running ❑ Walking ❑ Other:

Also have: ❑ Back pain ❑ Dementia ❑ Diabetes ❑ Fatigue ❑ Numbness ❑ Osteoporosis ❑ Over weight ❑ Swell

pHeadaches ❑ Infection ❑ Muscle spasm pWear orthotics ❑ Weakness ❑ Other:

Current Conditions—mark NONE if the condition below does NOT apply to you

Symptoms: ❑ **None** ❑ Chills ❑ ExcessiveWeightGain/Loss ❑ Fatigue ❑ Fever ❑ Loss of appetite ❑ Night sweats

Eyes: ❑ **None** ❑ Double vision ❑ Dry eyes ❑ Loss of vision ❑ Pain ❑ Redness ❑ Other:

Ears, Nose, Throat: ❑ **None** ❑ Ear pain ❑ Ear ringing ❑ Dizziness ❑ Hearing loss ❑ Hoarseness ❑ Loss of smell

Heart: ❑ **None** ❑ Chest pain ❑ Rapid heart rate ❑ Shortness of breath ❑ Swelling in legs or feet

Respiratory: ❑ **None** ❑ Productive cough ❑ Shortness of breath ❑ Snoring ❑ Sleep apnea ❑ Wheezing ❑ Other:

Intestinal: ❑ **None** ❑ Abdominal Pain ❑ Bloating/Gas ❑ Constipation ❑ Diarrhea ❑ Nausea ❑ Vomiting

Urinary, Reproductive: ❑ **None** ❑ Blood Urine ❑ Pregnant

Musculoskeletal: ❑ **None** ❑ Artificial joints ❑ Soft tissue pain

Skin: ❑ **None** ❑ Ingrown nail ❑ Lesion ❑ Non-healing wound

Neurological: ❑ **None** ❑ Memory loss ❑ Migraines ❑ Numbness ❑ Paralysis ❑ Seizures ❑ Strokes

Psychiatric: ❑ **None** ❑ Anxiety ❑ Claustrophobia ❑ Depression ❑ Hallucinations ❑ Restlessness

Endocrine: ❑ **None** ❑ Cold intolerance ❑ Diabetes ❑ Excessive thirst ❑ Excessive urination ❑ Heat intolerance

Hematological: ❑ **None** ❑ Anemia ❑ Blood transfusions ❑ Easy bruising ❑ Prolonged bleeding ❑ Other:

Immunologic: ❑ **None** ❑ Allergies ❑ HIV ❑ Recurrent Infections ❑ Other:

Pharmacy and Current Medications:

Pharmacy: **Location:** **Zip:** **Phone:**

Medication	Dosage	How Often	Medication	Dosage	How Often

Print Name of Patient or Legal Authorized Representative Signature Relationship to Patient Date