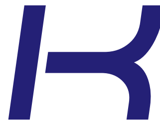

PATIENT HISTORY

Medical History

General Health (check one) ___Excellent ___Good ___Fair ___Poor

Have you had any medical problems or hospitalizing in the past year? ___Yes ___No

If "yes", please specify:
1. ______________________________
2. ______________________________
3. ______________________________

Surgical History: Procedure: ______________________ Date: __________
Procedure: ______________________ Date: __________

Prescription Medications: ______________________________

Over-the-counter Medications: ______________________________

Foot or Ankle Pain? ____Yes ___No

Past Injury/Problem History

	Date	Injury	Whom Seen	Treatment	Recovery Time
1.					
2.					
3.					

Present Injuries/Problems (if applicable):

Date of Injury/Onset: ______________________ Body Part(s): ______________________

Mechanism of Injury: ______________________________

Type of Onset (check one): ____ Gradual ____ Sudden

Symptoms at the time of onset: ______________________________

Current symptoms (aggravate/relieve): ______________________________

____

Present/past medical conditions (circle):

Asthma	Y	N	Heart Attack	Y	N
Arthritis	Y	N	Heart Disease	Y	N
Cancer	Y	N	Hernia	Y	N
Chemical Dependency	Y	N	High Blood Pressure	Y	N
Circulatory Disease	Y	N	Kidney Disease	Y	N
Depression	Y	N	Metal/other implant	Y	N
Diabetes	Y	N	Multiple sclerosis	Y	N
Dizziness	Y	N	Nervous Disorder	Y	N
Eating Disorder	Y	N	Numbness	Y	N
Emphysema	Y	N	Osteoporosis	Y	N
Epilepsy	Y	N	Pregnancy	Y	N
Fainting	Y	N	Stroke	Y	N
Fatigue	Y	N	Thyroid Problems	Y	N
Headaches	Y	N	Tuberculosis	Y	N
Hepatitis	Y	N	Weakness	Y	N
Fever/chills/sweats	Y	N	Night Pain	Y	N
Unexplained weight change	Y	N	Dyspnea	Y	N
Nausea/vomiting	Y	N	Dysuria	Y	N
Bowel dysfunction	Y	N	Polio	Y	N
Urinary frequency changes	Y	N	HIV +	Y	N

Comments: ______________________________

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