Appalachian Foot and Ankle Associates P.A.

Patient Health History

Patient Name_____ **Date** _____ **ID#** _____

Chief Complaint (Specific reason for your visit) _____

Describe pain or discomfort (circle) ☐ Burning ☐ Throbbing ☐ Sharp ☐ Dull ☐ Aching ☐ Numbness ☐ Tingling ☐ Shooting

How intense is your pain? 0 = none, 10 = severe (circle) 0 1 2 3 4 5 6 7 8 9 10

How long has the condition existed? _____ days _____ weeks _____ months _____ years

Is condition due to an accident/injury? Yes No Date of accident/injury _____
If yes, is it work related? Yes No How accident/injury occurred _____

Primary Care Provider: _____ **Approximate Date of Last Visit:** _____

Do you have or have you ever had any of the following?

____ Prone to Infection
____ Cancer
____ Diabetes
____ AIDS or HIV+
____ Hepatitis
____ Foot or Leg Injuries
____ Acid Reflux
____ Stomach Ulcers
____ Foot or Leg Cramps
____ Foot or Leg Numbness
____ Knee Pain
____ Unequal Leg Length
____ Bunions
____ Foot Skin Problems
____ Bursitis or Arthritis

____ Toe Nail Problems
____ High Blood Pressure
____ Foot or Leg Swelling
____ Lupus
____ High Cholesterol
____ Thyroid Problems
____ Fever, Chills, Night Sweats
____ Low Back Pain
____ Liver Disease
____ Epilepsy
____ AFib
____ Irreg. Heartbeat
____Stent
____Heart Surgery
____Foot/Leg Ulcers

____ Polio
____ Asthma
____ Anemia
____ Gout
____ Fainting Spells
____ Bleeding Tendency
____ Blood Disease
____ Circulation Problems
____ Fibromyalgia
____ Varicose Veins
____ Peripheral Neuropathy
____ PVD
____ DVT/Blood Clots
____ Other _____
_____

Office Use:
HT: _____
Wt: _____
Pulse: _____
BP: _____
SO02: _____
Temp: _____

Shoe Size: ____
Measure:
RT _____
LT _____

Family History of: **Diabetes** Yes No **Heart Disease** Yes No **High Blood Pressure** Yes No

LIST ALLERGIES: _____

LIST CURRENT MEDICATIONS (Include mg./dosage and any OTC products):

_____

_____

LIST PAST SURGICAL PROCEDURES: _____

Have you had previous treatment by a podiatrist? Yes No **When?** _____ **What for?** _____

Use of Alcohol: ____ Never ____ Rarely ____ Socially ____ Moderately ____ Daily
Use of Tobacco: ____ Never ____ Previously, but quit ____ Socially ____ Daily Current Packs per Day: _____
Use of Drugs: ____ Never ____ Socially ____ Daily Type of Recreational Drug _____

To the best of my knowledge, these questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my health status. I hereby give Appalachian Foot and Ankle Associate, Dr. Costanzo, Dr. Rehm, Dr. Szypczak, and/or Dr. Sheedy permission to perform the necessary services I may need.

X_____
Signature of Patient, Parent/Guardian, or Power of Attorney