Lansdowne Foot & Ankle Center
Patient Medical History Form

If you are unable to complete and print this form electronically, please arrive 20 minutes early to your appointment

Last Name _____ First Name _____ MI _____

◯ Male ◯ Female Shoe Size _____ Height _____ Weight _____ Age _____

History of Present Illness

1. What specific problem brings you to our office today? _____

2. Where is the pain/condition located? ☐ left foot/ankle ☐ right foot/ankle ☐ both

3. How long ago did this problem first start? _____

4. How would you describe the nature of your pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Throbbing ☐ Soreness Other _____

5. How would you rate your pain on a scale from 0 to 10? ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

6. What seems to make the pain/condition feel worse? ☐ Walking ☐ Standing ☐ Resting ☐ Dress Shoes ☐ Flat Shoes ☐ Any Closed Shoe ☐ Daily Activities ☐ Exercise

7. What makes condition feel better? _____

8. What treatments have you tried for this condition? _____

9. Is this problem the result of an injury? ◯ Yes ◯ No If yes, is it work related? ◯ Yes ◯ No

10. Do you participate in competitive sports? ◯ Yes ◯ No

Allergies:

- ☐ None
- ☐ Adhesive Tape
- ☐ Iodine/Shellfish
- ☐ Penicillin
- ☐ Aspirin
- ☐ Local Anesthetics
- ☐ Sulfa
- ☐ Codeine
- ☐ Demerol
- ☐ Novocaine

Other _____

Medications:
(include prescriptions, over-the-counter medications and vitamins)

Previous Surgeries: (Please list & include dates)

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Patient Medical History Form

(continued)

Anemia	◯ Yes	◉ No	Hepatitis or Jaundice	◯ Yes	◉ No
Angina	◯ Yes	◉ No	High Blood Pressure	◯ Yes	◉ No
Arthritis	◯ Yes	◉ No	HIV/AIDS	◯ Yes	◉ No
Artificial Joints	◯ Yes	◉ No	Kidney Problems	◯ Yes	◉ No
Asthma	◯ Yes	◉ No	Liver Disease	◯ Yes	◉ No
Back Problems	◯ Yes	◉ No	Low Blood Pressure	◯ Yes	◉ No
Bleeding Disorders	◯ Yes	◉ No	Mental Health Disorders	◯ Yes	◉ No
Cancer	◯ Yes	◉ No	Neuropathy	◯ Yes	◉ No
Chest Pain	◯ Yes	◉ No	Phlebitis	◯ Yes	◉ No
Chronic Diarrhea	◯ Yes	◉ No	Radiation Treatment	◯ Yes	◉ No
Circulation Problems	◯ Yes	◉ No	Respiratory Disease	◯ Yes	◉ No
Diabetes	◯ Yes	◉ No	Rheumatic Fever	◯ Yes	◉ No
Ear Problems	◯ Yes	◉ No	Shortness of Breath	◯ Yes	◉ No
Epilepsy	◯ Yes	◉ No	Sinus Problems	◯ Yes	◉ No
Eye Problems	◯ Yes	◉ No	Skin Conditions	◯ Yes	◉ No
Fainting or Dizzy Spells	◯ Yes	◉ No	Slow or Non-healing Wounds	◯ Yes	◉ No
Foot or Leg Cramps	◯ Yes	◉ No	Special Diet	◯ Yes	◉ No
Gout	◯ Yes	◉ No	Stroke	◯ Yes	◉ No
Headaches	◯ Yes	◉ No	Tuberculosis	◯ Yes	◉ No
Heartburn	◯ Yes	◉ No	Ulcers	◯ Yes	◉ No
Heart Disease	◯ Yes	◉ No	Varicose Veins	◯ Yes	◉ No
Hemophilia	◯ Yes	◉ No	Venereal Disease	◯ Yes	◉ No

Women Only

Are You Pregnant	◯ Yes	◉ No
Breast Feeding	◯ Yes	◉ No
Regular Menstrual Cycle	◯ Yes	◉ No

Social

Do you smoke? ◯ Yes ◯ No If yes, what type/frequency? _____

Do you drink alcohol? ◯ Yes ◯ No If yes, how much? _____

Do you use drugs? ◯ Yes ◯ No If yes, what type/frequency? _____

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(continued)

Review of Systems: Are you experiencing any of the following conditions?

Constitutional

Nausea/Vomiting	◯ Yes	◉ No
Fever/Chills	◯ Yes	◉ No
Recent Weight Loss	◯ Yes	◉ No
Recent Weight Gain	◯ Yes	◉ No

Eyes

Eye Disease or Injury	◯ Yes	◉ No
Wear Glasses/Contacts	◯ Yes	◉ No
Blurred or Double Vision	◯ Yes	◉ No

Ear/Nose/Mouth/Throat

Hearing Loss	◯ Yes	◉ No
Nose Bleeds	◯ Yes	◉ No
Sore Throat	◯ Yes	◉ No
Sinus Problems	◯ Yes	◉ No
Difficulty Swallowing	◯ Yes	◉ No

Cardiovascular

Chest Pain	◯ Yes	◉ No
Palpitations	◯ Yes	◉ No
Heart Disease	◯ Yes	◉ No
Murmur	◯ Yes	◉ No
Arrhythmia	◯ Yes	◉ No
Leg Pain When Walking	◯ Yes	◉ No

Endocrine

Hormonal Problem	◯ Yes	◉ No
Excessive Thirst	◯ Yes	◉ No
Excessive Urination	◯ Yes	◉ No
Heat Intolerance	◯ Yes	◉ No
Cold Intolerance	◯ Yes	◉ No

Gastrointestinal

GI Upset	◯ Yes	◉ No
GI or Rectal Bleeding	◯ Yes	◉ No
Abdominal Pain	◯ Yes	◉ No

Genitourinary

Frequent Urination	◯ Yes	◉ No
Burning or Painful Urination	◯ Yes	◉ No
Kidney Stones	◯ Yes	◉ No

Musculoskeletal

Joint Pain	◯ Yes	◉ No
Stiffness	◯ Yes	◉ No
Swelling	◯ Yes	◉ No
Lower Back Pain	◯ Yes	◉ No

Respiratory

Difficulty Breathing	◯ Yes	◉ No
Shortness of Breath	◯ Yes	◉ No
Lung Disease	◯ Yes	◉ No

Integumentary

Edema or Swelling	◯ Yes	◉ No
Rash	◯ Yes	◉ No
Itching	◯ Yes	◉ No

Neurological

Headaches	◯ Yes	◉ No
Seizures	◯ Yes	◉ No
Numbness	◯ Yes	◉ No
Tingling	◯ Yes	◉ No
Burning	◯ Yes	◉ No

Psychiatric

Anxiety	◯ Yes	◉ No
Depression	◯ Yes	◉ No
Nervousness	◯ Yes	◉ No

Hematological

Phlebitis	◯ Yes	◉ No

Family History:
(Please list all medical conditions that may run in the family)

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Print Name of Patient, Parent or Guardian

Signature of Patient, Parent or Guardian

Date

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Confidential Patient Information

How did you hear about us? (if physician, please specify)

Primary Care Physician Name

Date last seen by Primary Care Physician Does your insurance policy require a referral? ◯ Yes ◯ No

Patient Information (please type or print)

Last Name First Name MI

Date of Birth: Age ◯ Male ◯ Female Social Security #:

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Address

City State Zip Code

Home Phone Work Phone Cell Phone email

Pharmacy Pharmacy Location Pharmacy Phone

Race Ethnicity Preferred language

Emergency Contact Phone

Policy Holder (if patient, write "Self")

Last Name First Name MI

Address

City State Zip Code

Relationship to Patient ◯ Spouse ◯ Parent ◯ Other Policy Holder SSN#

Date of Birth ◯ Male ◯ Female

Insurance Information

Name of Insurance Company

Policy Number Group Number

Secondary Insurance Company (if applicable)

Policy Number Group Number

Print Completed Form