UT★Physicians

Foot and Ankle – New Patient History

Patient Name:____ **Age:**__________ **Date:**________________
Occupation:____ **Sex:** ☐ M ☐ F **Birthdate:**____________
Who referred you?____ **Height:**________ **Weight:**_____________
Preferred Pharmacy:____ **Shoe Size:**_____________
____

Current Problem: ☐Left ☐Right____**Date problem began:**________________
Are you having any of the following symptoms? (check all that apply)
☐Pain- rate on scale of 1 to 10:_ /10 ☐Swelling ☐Redness ☐Limited Motion ☐Limping ☐Loss of muscle
☐Popping ☐Catching/Locking ☐Stiffness ☐Numbness ☐Deformity ☐Mass
How frequent are the symptoms? ☐Rare ☐Occasional ☐Intermittent, but frequent ☐Constant ☐Other:_____________
Have you been treated for this problem before today? ☐No ☐Yes
What kind of treatment? ☐Medication ☐Injection ☐Splint/Brace ☐Therapy ☐Surgery ☐X-rays ☐MRI ☐Other:_____________
What makes the problem better? ____
What makes the problem worse? ____
Have you seen any other providers for this problem? ☐No ☐Yes, who? ____

Are you allergic to any medications? ☐No ☐Yes, list: ____
Have you ever had an adverse reaction to a blood transfusion? ☐No ☐Yes
Do you have an allergy to tape or adhesives? ☐No ☐Yes Have you ever had problems with anesthesia? ☐No ☐Yes

Do you take any medications? ☐No ☐Yes Ever used steroid medications (cortisone, prednisone, etc.)? ☐No ☐Yes

Medication	Dose	How Often Taken

Any hospitalizations or surgery? ☐No ☐Yes

Surgery Type	Date	Surgery Type	Date

Social History: Tobacco - ☐No ☐Yes, how much? ____________________ Drugs - ☐No ☐Yes, how often?____________________
Alcohol - ☐No ☐Yes, how much? ____________________ Exercise - ☐No ☐Yes, how often?____________________

Past Medical History: Do you have or have you ever had any prior medical conditions? Check all that apply:
☐Diabetes, Last A1c_ ☐Depression ☐Neuropathy ☐Heart Attack ☐Heart disease ☐Hypertension ☐Stroke ☐Cancer
☐Lung disease ☐Asthma ☐Blood clots ☐Excessive bleeding ☐Pulmonary embolism ☐Kidney Disease ☐Broken bones
☐Ulcer ☐Hepatitis ☐Infection ☐AIDS/HIV ☐Chronic wounds ☐Diabetic Ulcer ☐TB (tuberculosis) ☐MRSA
☐Other:____

Females only: Are you pregnant? ☐No ☐Yes, how far along?________________________
Are you currently taking any birth control pills? ☐No ☐Yes, how long? ________________________

Family History: Have any blood relatives ever had any of the following? If so, indicate their relationship to you (e.g. Clubfoot – brother)

☐No family medical problems ☐Diabetes ☐Heart disease ☐Blood Disease ☐Cancer
☐Pulmonary embolism ☐Blood Clot ☐Easy bleeding ☐Liver Trouble ☐Stroke
☐Psychiatric Disease ☐Anesthesia complications ☐Tuberculosis
☐Other:____

Review of Systems: Check all symptoms that you have experienced recently. ALL SECTIONS MUST HAVE A RESPONSE

General
- ☐No symptoms
- ☐Weight loss/gain
- ☐Poor appetite
- ☐Fever
- ☐Chills
- ☐Night sweats

Skin
- ☐No symptoms
- ☐Rash
- ☐Hives
- ☐Lesions

Head/Eyes/Ears/Nose/Throat
- ☐No symptoms
- ☐Hay fever
- ☐Postnasal drip
- ☐Hoarseness
- ☐Visional problems
- ☐Nose bleeds
- ☐Neck stiffness/pain

Psychiatric
- ☐No symptoms
- ☐Anxiety
- ☐Depression

Pulmonary
- ☐No symptoms
- ☐Shortness of breath
- ☐Wheezing
- ☐Coughing

Genitourinary
- ☐No symptoms
- ☐Frequent urination
- ☐Painful urination
- ☐Blood in urine
- ☐Discharge
- ☐Kidney pain

Gastrointestinal
- ☐No symptoms
- ☐Indigestion
- ☐Nausea
- ☐Vomiting
- ☐Diarrhea
- ☐Constipation
- ☐Bloody stools
- ☐Yellow skin
- ☐Abdominal pain

Musculoskeletal
- ☐No other symptoms
- ☐Joint pain
- ☐Swelling
- ☐Redness
- ☐Limited motion
- ☐Weakness
- ☐Atrophy
- ☐Cramps
- ☐Popping
- ☐Locking/catching
- ☐Stiffness
- ☐Numbness
- ☐Tingling
- ☐Mass
- ☐Deformity

Lymphatics
- ☐No symptoms
- ☐Lymph node swelling
- ☐Node tenderness

Endocrine
- ☐No symptoms
- ☐Excessive urination
- ☐Excessive thirst
- ☐Excessive appetite
- ☐Hot intolerance
- ☐Cold intolerance
- ☐Easy bleeding

Cardiovascular
- ☐No symptoms
- ☐Chest pain
- ☐Rapid heart beat
- ☐Irregular heart beat
- ☐Rheumatic fever

Neurologic
- ☐No symptoms
- ☐Headaches
- ☐Dizziness
- ☐Loss of consciousness
- ☐Seizures

☐Other
____
____

I certify that the information provided above is true.

______________________________ ______________________________
Signature **Date**

Relationship to patient: ☐Self ☐Parent or Legal Guardian ☐Other (please specify):______________________________

Provider Notes: ____
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I have reviewed the past history with the patient and/or family members and confirm the information listed in the above questionnaire.

______________________________ ______________________________
Provider Signature **Date**