ORTHOPAEDIC & RECONSTRUCTIVE CENTER

PATIENT INFORMATION

1044 S.W. 44th Oklahoma City, OK 73109

Date: _____

☐ Male ☐ Female

Last Name _____ First _____ Middle Initial: _____

☐ Left Hand Dominant
☐ Right Hand Dominant

Date of Birth _____ Age _____ Height _____ Weight _____ Shoe Size _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

REASON FOR YOUR VISIT TODAY Your Current Problem: _____

Location on Foot or Leg: Check all that apply
☐ Forefoot/Toes ☐ Middle Foot ☐ Back Part of Foot
☐ Ankle ☐ Top ☐ Bottom
☐ Outer Side ☐ Inner Side

How Long Has This Bothered You? _____
How Did This Begin? _____
What Course has it Taken? _____
What Aggravates it? _____
What Makes it Feel Better? _____
What Have You Done to Relieve the Condition? _____

Have you ever been to a podiatrist before? ☐ NO ☐ YES If yes, please list. Name: _____
Who is your Family Physician or Primary Care Physician? _____
Who may we Thank for Referring you to us? _____

Podiatry History- Check if you have, or have had, any symptoms in the following areas to a significant degree.

☐ Painful corns
☐ Ankle Pain
☐ Flat Feet
☐ Bunion Pain
☐ Rash on foot
☐ Circulation
☐ Recent changes in weight
☐ Warts (top/bottom of foot)
☐ Heel pain/arch pain
☐ Trauma or injury
☐ Itching on feet
☐ New exercise
☐ Numbness or tingling in feet
☐ Shooting pain in feet & lower legs
☐ Ability to sleep due to foot pain
☐ Hammertoes-curled toes
☐ Other pain/discomfort: _____
_____

What are you feeling today? Check all that *currently* apply:

☐ a.m. stiffness
☐ blood clots
☐ coughing
☐ heart palpitations
☐ loss of bladder/bowel control
☐ pain with breathing
☐ tingling
☐ arm/neck pain with exertion
☐ bruise easily
☐ difficulty walking
☐ leg swelling/pain
☐ loss of motion
☐ problem with balance
☐ tremors

(Review of Symptoms)

☐ bladder infection ☐ bleeding disorder
☐ chest pain ☐ cold hands
☐ flu ☐ headaches
☐ loss of consciousness
☐ night sweats ☐ numbness
☐ reflux ☐ shortness of breath
☐ wheezing ☐ weight change

This usually happens: ☐ after walking a block ☐ while lying in bed ☐ after being on feet
How long does this last? _____

Have you ever had? Check all past or current illnesses:

(Past Medical History)

☐ anemia
☐ diabetes
☐ heart attack
☐ HIV/AIDS
☐ osteoporosis
☐ stroke/TIA
☐ asthma
☐ emphysema
☐ heart disease
☐ kidney problems
☐ rheumatoid arthritis
☐ thyroid condition
☐ cancer
☐ gout
☐ heart failure
☐ liver disease
☐ scoliosis
☐ tuberculosis
☐ chronic bronchitis
☐ hepatitis
☐ high blood pressure
☐ osteoarthritis
☐ seizures
☐ ulcers
☐ Other: _____

Please list all past surgical procedures and date: 1. /Date:

2. /Date: 3. /Date:

4. /Date: 5. /Date:

Have you ever had any complications from anesthesia? ☐ NO ☐ YES, _____

WOMEN: Are you, to your knowledge, Pregnant? ☐ NO ☐ YES

Current Medications: list all medications, including over-the-counter. Go to back of form if more than 6 medications.

NAME OF MEDICATION	DOSAGE	FREQUENCY
See back for add'l meds? Yes No		

Allergies: Are you allergic or sensitive to any medication(s)? ☐ YES (If yes, please specify below) ☐ NO

☐ Penicillin ☐ Novacain ☐ Anesthetics ☐ Adhesive Tape ☐ Iodine ☐ Metal

☐ Drugs: _____

☐ Other: _____

FAMILY MEDICAL HISTORY -Please check all found in your family:

	You	Family		You	Family
Diabetes			Epilepsy		
Heart Trouble			Nerve Disease		
Blood vessel disease			Nervous Condition		
High Blood Pressure			Muscle disease		
Bleeding Problems			Bone disease		
Kidney trouble			Varicose veins		
Liver Problems			Arthritis		
Anemia			Cancer		
Lung Disease			Rheumatic fever		
Blood Disease			Asthma		
Lymph Disease			Gout		

SOCIAL HISTORY

Have you ever smoked? ☐ YES ☐ NO

If YES, do you smoke now? ☐ YES

If no longer smoking, when did you stop? _____

Packs/day: _____

For how many years? _____

Do you drink alcohol? ☐ YES ☐ NO

Amount: _____ How often? _____

Do you use drugs for recreation? ☐ YES ☐ NO

Type/Frequency: _____

Work History: Present Occupation: _____ Currently Working? ☐ YES ☐ NO

Previous Occupation/Jobs: _____ _____

Exercise: ☐ Sedentary (No exercise) ☐ Occasional vigorous exercise (work or recreation, less than 4x/week for 30 min.)

☐ Mild Exercise ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)

Athletic activities in which you participate: Please list and indicate frequency

_____

_____

_____

_____ _____

Patient Signature Date