Quad Cities Foot & Ankle Associates, P.C.

Medical Health History Form - PMFSH and ROS

PLEASE COMPLETE BOTH PAGES AND SIGN THE FORM AT THE BOTTOM OF PAGE 2. IT IS VERY IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL QUESTIONS.

Name: _____ Reason for visit: _____

Height: _____ Weight: _____ Shoe Size _____

Language: _____ Ethnicity (Please circle): Hispanic or Latino Not Hispanic or Latino

Race (Please circle): American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Caucasian

Please list regular Family or Medical Doctor, (Name, Address, and Phone #):

_____

Date Last Seen: _____

PAST MEDICAL AND SURGICAL HISTORY: Please circle if you have, or have ever had, any of the following conditions –

high blood pressure	sleep apnea	seizure disorder	stomach problems	rheumatoid arthritis	bleeding disorder
irregular heart beat	emphysema	depression	esophageal reflux	osteoarthritis	blood clots
heart disease	lung disease	anxiety	ulcer disease	hypothyroid (low)	hyperthyroid (high)
heart attack	pneumonia	stroke	liver disease	cancer – if yes, what type _____	
heart failure	asthma	mental illness	hepatitis	adult diabetes – if yes, do you use insulin Yes / No (circle one)	
any prior problems with anesthesia		HIV/AIDS	kidney disease	childhood diabetes – if yes, do you insulin Yes / No (circle one)	

List any other medical conditions not listed above:

_____ _____

_____ _____

_____ _____

Please list ALL surgeries you've had: ☐ None

_____ _____

_____ _____

_____ _____

MEDICATIONS: Please list ALL medications you currently take, please include the frequency and dosage-

☐ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Marital Status: _____

Alcohol Use (type, amount): _____

Tobacco Use (amount, years used): _____

ALLERGIES: Please list any allergies to medications that you have, With the type of reaction caused by the medication-

☐ No known allergies

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY: Please list any health problems of parents, (if deceased, how), and any medical problems in your family-

Mother: _____

Father: _____

Other Family Members such as Grandparents and Siblings:

_____

PLEASE CONTINUE AND COMPLETE THE SECOND PAGE OF THIS FORM

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REVIEW OF SYSTEMS: Please circle if you have any of the following symptoms – please also give a brief description -

Constitutional: fever, recent weight gain/loss, appetite problems _____

Eyes: double vision, blurring, difficulty seeing _____

Ears, Nose, Mouth, Throat: deafness, sinusitis, hoarseness, dizziness _____

Cardiovascular: chest pain, palpitations, calf muscle pain with exercise _____

Respiratory: shortness of breath, wheezing, cough, bloody cough _____

Gastrointestinal: abdominal pain, constipation, diarrhea, rectal bleeding _____

Urologic: pain with urinating, hesitant urination, bleeding, incontinence _____

Gynecologic: Is there any chance you could be pregnant now? **Yes / No (please circle one)**

Skin: persistent rashes or lesions, changes in moles, itching, redness _____

Neurologic: seizures, loss of balance/coordination, weakness, numbness in feet _____

Psychiatric: depression, anxiety, hallucinations, sleep disturbances _____

Endocrine: excessive thirst, excessive urination, heat/cold intolerance _____

Blood and Lymphatic: anemia, bleeding tendencies, swollen nodes _____

Allergic and Immunologic: hives, eczema, persistent itching _____

Musculoskeletal: stiffness, joint pain/deformity, muscle wasting, spine pain radiating to arms or legs, numbness/tingling _____

_____

Other problems not covered above: _____

_____

PATIENTS PLEASE SIGN FORM HERE: **Patient:** _____ **Date:** _____

FOR PRACTITIONER USE ONLY - I have reviewed and updated the above past medical, family and social history with the patient:

Practitioner: _____ Date: _____

Practitioner: _____ Date: _____