FOOT AND ANKLE CENTER OF DURHAM
A division of InStride Foot & Ankle Specialists

Patient's Name: _____ Height: _____ Weight: _____ Shoe Size: _____ Date:_____

Chief foot complaint:_____How long have you had this problem?_____

Is the problem injury related? ☐ Yes ☐ No If yes, date of injury:_____Was the injury at work? ☐ Yes ☐ No
If so, is there a Worker's Comp claim? ☐ Yes ☐ No Worker's Comp Contact:_____ Phone: _____

Briefly describe the problem: _____

Have you received prior treatment from a physician or treated it yourself? (Check all that apply): ☐ No prior treatment

☐ Treatment:_____Surgery:_____When?_____ ☐ Antibiotic ☐ Anti-inflammatory
☐ Change in shoe gear ☐ Orthotics or insoles ☐ OTC products ☐ Trimming or cutting of lesions

Allergies: (Please check any drug/medication allergies you may have) ☐ No known drug allergies
☐Aspirin ☐Codeine ☐Latex ☐Lidocaine ☐Penicillin ☐Sulfa ☐ Other:_____

Medications
List all current medications (if you have a list, we can copy it): ☐No current medications ☐ See attached list

Drug Name	Strength (mg)	Frequency (how often?)	Prescribed by:

Pharmacy_____City/Street:_____

Medical History: (Check all you have or have had in the past)

☐ Alzheimer's	☐ Blood Clots	☐ Gout	☐ Kidney disease	☐ Stroke
☐ Anemia	☐ Cancer:_____	☐ Heart Disease	☐ Osteoporosis	☐ Thyroid disease
☐ Arthritis	☐ Diabetes Type I II	☐ HIV	☐ PVD	☐ Tuberculosis
☐ Asthma	☐ GI _____	☐ Hypertension	☐ Liver disease/hepatitis	☐ Other:_____

Surgical History: (Please check all that apply) ☐None apply
☐Angioplasty ☐Stent placement ☐Back surgery ☐Hip replacement ☐Knee replacement ☐Pacemaker
☐Surgery of the Ankle/Foot: ☐Bunion ☐Hammertoe ☐Joint fusion ☐Fracture

Social History
Tobacco: ☐Current smoker ☐Former Smoker ☐Never smoker Alcohol: ☐Never ☐Sometimes ☐Formerly

Family History

Alcoholism	Father	Mother	Brother	Sister	Heart Disease	F	M	B	S	Peripheral Vascular Disease	F M B S
Diabetes	F	M	B	S	Hypertension	F	M	B	S	Renal (kidney) disease	F M B S
Gout	F	M	B	S	Osteoarthritis	F	M	B	S	Stroke	F M B S
Cancer	F	M	B	S	Osteoporosis	F	M	B	S	Other:_____	F M B S

Review of Systems: (Please mark any current symptoms you are experiencing) ☐None of the following apply
Const: ☐Fatigue ☐Fever/Chills ☐Night Sweats ☐Recent weight loss/gain Skin: ☐Dry ☐Itchy ☐Rash
GU: ☐Frequent urination ☐Urinary incontinence Hem: ☐Easy bleeding ☐Easy bruising
Endo: ☐Heat/cold intolerance ☐Excessive sweating ☐Loss of body hair Resp: ☐Cough ☐Shortness of breath
Neuro: ☐Headaches ☐ Memory loss ☐Numbness/tingling Psych: ☐Anxiety ☐Depression
EENT: ☐Vision impairment/loss ☐Blurry vision ☐Hearing loss ☐Ringing in ears
Cardio: ☐Chest pain ☐Palpitations ☐Leg pain with exercise ☐Varicose Veins
GI: ☐Difficulty swallowing ☐Heartburn ☐Nausea ☐Vomiting ☐ Abdominal pain ☐Diarrhea ☐Constipation
MS: ☐Loss of muscle strength ☐Muscle weakness ☐Joint pain ☐ Back pain ☐Joint stiffness ☐Muscle aches

_____ _____
Signature of Patient or Person Completing Medical History Date