



PATIENT HEALTH HISTORY

17400 Irvine Blvd, Ste H • Tustin, CA 92780 • Tel: 714.832.7212 • Fax: 714.832.0554

TODAY'S DATE: _____

PATIENT'S NAME: _____ BIRTHDATE: _____ AGE: _____
(LAST, FIRST, MIDDLE)

FAMILY DOCTOR: _____
DATE OF LAST VISIT: _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

PHONE: _____

PREVIOUS PODIATRIST NAME: _____
DATE OF LAST VISIT: _____

HEIGHT: _____ WEIGHT: _____ SEX: male female

BRIEFLY DESCRIBE YOUR FOOT/ANKLE PROBLEM:

HOW LONG?: _____

HAVE YOU BEEN TREATED FOR THIS CONDITION BEFORE? YES NO

HOW? _____

HAVE YOU EVER HAD FOOT X-RAYS? YES NO

IF SO, WHEN? _____
FOR WHAT CONDITION? _____

IF FEMALE, ARE YOU PREGNANT? YES NO

IF SO, HOW MANY MONTHS? _____
LAST MENSTRUAL PERIOD: _____

ARE YOU IN GOOD HEALTH? YES NO

DO CUT AND WOUNDS HEAL SLOWLY? YES NO

ARE YOU SUBJECT TO PROFUSE BLEEDING? YES NO



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MEDICAL HISTORY: PLEASE CHECK IF ANY OF THE FOLLOWING PROBLEMS EXIST OR HAVE OCCURED IN THE PAST

- | | | |
|--|--|---|
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> TROUBLE SWALLOWING |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> HEAT MURMUR | <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> HEAD INJURIES |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> PALPITATIONS | <input type="checkbox"/> BROKEN BONES |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> STROKE | <input type="checkbox"/> ANKLE SPRAINS |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> SICKLE CELL ANEMIA | <input type="checkbox"/> INFECTIONS |
| <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> BLEEDING PROBLEMS | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> LOW BACK PAIN |
| <input type="checkbox"/> NERVOUS CONDITIONS | <input type="checkbox"/> PHLEBITIS | <input type="checkbox"/> LEG CRAMPS |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> NUMBNESS TO FEE/LEGS |
| <input type="checkbox"/> STOMACH TROUBLE | <input type="checkbox"/> VARICOSE VEINS | <input type="checkbox"/> COLLAGEN VASC. DISEASE |
| <input type="checkbox"/> SWELLING IN ANKLES/FOOT | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> AIDS OR HIV EXPOSURE |
| <input type="checkbox"/> GROUT | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> NASAL POLYPS |
| | | <input type="checkbox"/> OTHER |

ARE YOU TAKING ANY MEDICATIONS (PRESCRIPTION, BIRTH CONTROL PILLS, OR OVER-THE-COUNTER)? YES NO
IF YES, WHAT ARE THEY: _____

SHORTNESS OF BREATH: YES NO

NERVOUS CONDITIONS: YES NO

LOW BACK PAIN: YES NO

OTHER: _____

ALLERGIES:

- | | |
|--|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> FOODS |
| <input type="checkbox"/> PENICILLINS | <input type="checkbox"/> ASPIRIN |
| <input type="checkbox"/> SULFA | <input type="checkbox"/> ADHESIVE TAPES |
| <input type="checkbox"/> LOCAL ANESTHETICS | <input type="checkbox"/> IODINE |
| <input type="checkbox"/> CODEINE | <input type="checkbox"/> OTHER: _____ |

SOCIAL HISTORY:

- | | |
|--|---|
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> HEARTH DISEASE | <input type="checkbox"/> BLOOD DISEASES |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> FOOT OR ANKLE PROBLEMS |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> CANCERS |
| <input type="checkbox"/> DRUG ALLERGIES | <input type="checkbox"/> OTHER: _____ |

PAST HOSPITALIZATIONS OR SURGERIES? _____

ANY OTHER MEDICAL CONDITIONS THAT WE SHOULD KNOW ABOUT?

