

# Bluegrass Regional Foot and Ankle Associates



## Podiatric and Medical History

What is your foot/ankle problem? \_\_\_\_\_

Which foot/ankle is it? (Circle one)      **RIGHT**      **LEFT**      **BOTH**

Where on your foot/ankle does your problem exist? \_\_\_\_\_

How long have you had your problem? \_\_\_\_\_

Has your problem gotten worse, better, or stayed the same? \_\_\_\_\_

Does anything make your problem worse? \_\_\_\_\_

Have you had any treatments for your problem? \_\_\_\_\_

Is there anything else you would like to tell us concerning your problem? \_\_\_\_\_

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**Allergies:**    Do you have any drug allergies?    YES    NO  
                  Do you have seasonal/environmental allergies?    YES    NO  
                  Do you have food allergies?    YES    NO

**I am allergic to:** Penicillin    Sulfa    Aspirin    Cephalosporins    Erythromycin    LATEX  
Iodine    Adhesive Tape    Novocaine/Lidocaine  
OTHER Drug Allergies: \_\_\_\_\_  
List of Food or Environmental allergies: \_\_\_\_\_

**Past Medical History: (CIRCLE YOUR Personal Medical History)**  
Aids/HIV    Alcoholism    Appendicitis    Asthma    Cancer    Diabetes    Emphysema    Gout  
Hepatitis    Hepatitis    High Blood Pressure    MS    Pacemaker    Pneumonia    Seizures    Stroke  
Thyroid Disorder    Ulcer(stomach)  
OTHER: \_\_\_\_\_

**Past Surgical History: (CIRCLE YOUR Personal Surgical History)**  
Amputation (toe) (foot) (leg)    Angioplasty    Ankle Sx    Appendectomy    Back Sx    C-section  
Eye Sx    Foot Sx    Hip Replacement    Knee Sx    Nail Removal    Thyroid Sx  
Tonsilectomy    Heart Surgery    Vascular Sx    Wisdom tooth removal  
OTHER: \_\_\_\_\_

**Family History: (CIRCLE your Blood Related Relatives Medical History)**  
Cancer    Depression    Diabetes    Genetic Disease    Heart Disease  
High Cholesterol    High Blood Pressure    Rheumatoid Arthritis    Stroke  
OTHER: \_\_\_\_\_

**Social History:** Alcohol Use - \_\_\_\_drinks per week    Illegal Drug Use    Smoking/Tobacco Use

**Review of Systems:(CIRCLE Conditions/Problems that you CURRENTLY have)**

**Constitutional:** Anxiety Dizziness Fever Headaches Nausea/Vomiting  
Increased thirst Tiredness Vertigo Weight Gain Weight Loss

**Cardiovascular:** Ankle Swelling Cramp in Calf Cardiovascular Problems  
Cold Feet Elevated BP Murmur Pacemaker Varicose Veins

**Endocrine:** Dry Hair Dry Skin Extreme Thirst Unusual Fatigue

**ENT:** Cough Difficulty Hearing Difficulty Swallowing Dry Mouth

**Eyes:** Wear Glasses Blurred Vision Dry Eyes Loss of Vision

**GI:** Blood in stool Constipation Diarrhea Heartburn (GERD) Hemorrhoids  
Rectal Bleeding Vomiting Yellowing of Skin

**Genitourinary:** Kidney Dialysis Currently Pregnant Urinary Frequency

**Immunologic:** Arthritic Flare-up Gout Attack Hepatitis Seasonal Allergies

**Skin:** Athletes Foot Blisters Burning of Skin Dermatitis Dry, Scaly Skin  
Itchy Skin Leg Ulcers Non-Healing Wounds Rash Tingling Sensation

**Lymphatic:** Calf Pain Legs Swelling Water Retention

**MSK:** Back Pain Weakness in Legs Heel Pain Hip Pain Joint Swelling  
Leg Cramps Morning Stiffness Muscle Tenderness

**Neurological:** Burning in Feet Numbness Paralysis Seizures Tingling

**Psychiatric:** Addiction - Alcohol Addiction - Drugs Anxiousness Depression  
Memory Loss Panic Attacks Emotional/Psychiatric difficulties

**Respiratory:** Difficulty Breathing Shortness of Breath Wheezing

**Rx & OTC Medications**

**Dosage How many times a day**

- 1) \_\_\_\_\_ \_\_\_\_\_ once twice three other:
- 2) \_\_\_\_\_ \_\_\_\_\_ once twice three other:
- 3) \_\_\_\_\_ \_\_\_\_\_ once twice three other:
- 4) \_\_\_\_\_ \_\_\_\_\_ once twice three other:
- 5) \_\_\_\_\_ \_\_\_\_\_ once twice three other:
- 6) \_\_\_\_\_ \_\_\_\_\_ once twice three other:
- 7) \_\_\_\_\_ \_\_\_\_\_ once twice three other:
- 8) \_\_\_\_\_ \_\_\_\_\_ once twice three other:
- 9) \_\_\_\_\_ \_\_\_\_\_ once twice three other:
- 10) \_\_\_\_\_ \_\_\_\_\_ once twice three other:

**Please List any other important medical information here:**