Ambulatory Foot Center

1619 NW Hawthorne Ave. St 110
Grants Pass, OR 97526
Office (541) 471-7056
Fax (541) 474-3201

HISTORY AND MEDICAL INFORMATION

Please print! Please present all your insurance cards to the receptionist to copy for our records.

PATIENT INFORMATION

Name________________________ Date of birth____________ Date____________

Primary Care Physician________________________

What is your height?__________ Weight?__________ Occupation________________

Explain your foot/ankle problem ________________________

When did your problem begin?________________________

Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Achy ☐ Other____________

What makes pain/discomfort better?________________________

What makes pain/discomfort worse?________________________

Has condition been medically treated?________ When and how? ________________

PAST MEDICAL HISTORY *(check all that apply)*

- ☐ Anemia
- ☐ Bleeding disorders
- ☐ COPD/Asthma
- ☐ DVT (Deep vein thrombosis)
- ☐ High cholesterol
- ☐ Poor circulation
- ☐ Stroke
- ☐ Joint replacement
- ☐ GI ulcers/heartburn
- ☐ Gout
- ☐ Heart disease
- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Nerve disorders
- ☐ Thyroid disorders
- ☐ Anticoagulant therapy
- ☐ Kidney disease
- ☐ Diabetes
- ☐ Epilepsy
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Arthritis
- ☐ Mitral valve prolapse
- ☐ Depression/Anxiety
- ☐ Other ________________

LIST ALL MEDICATIONS *(including vitamins and herbs)*

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ALLERGIES *(check all that apply)*

- ☐ None
- ☐ Penicillin
- ☐ Codeine/Narcotic
- ☐ Local Anesthetics
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Radiographic Contrast/Dyes
- ☐ Shellfish
- ☐ Other ________________

Patient's name ____________________

SOCIAL HISTORY

Do you smoke? __________ How much? __________ How long? __________

Prior smoker? __________ Alcohol use (drinks per week) __________

Drug use IV, recreational? __________

Females: Are you pregnant/nursing? __________

PRIOR SURGERIES *(include dates)*

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FAMILY HISTORY *(list family member who has had condition)*

- ☐ Diabetes
- ☐ Stroke
- ☐ Kidney disease
- ☐ Heart disease
- ☐ Cancer
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ High blood pressure
- ☐ Mental illness

Other family history __________

CHECK IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING

General

- ☐ Fever/Chills
- ☐ Dizziness
- ☐ Headaches
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue

Eyes, Ears, Nose and Throat

- ☐ Vision problems
- ☐ Hearing problems
- ☐ Nasal congestion
- ☐ Neck stiffness

Cardiovascular

- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Leg swelling

Respiratory

- ☐ Shortness of breath
- ☐ Cough

Musculatory

- ☐ Joint swelling/pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Muscle cramps

Skin

- ☐ Rash
- ☐ Itching

Neurologic

- ☐ Headaches
- ☐ Paralysis
- ☐ Numbness/tingling

Psychiatric

- ☐ Anxiety
- ☐ Depression

Endocrine

- ☐ Frequent thirst
- ☐ Frequent urination
- ☐ Cold/heat tolerance

Hematologic

- ☐ Tendency to bleed
- ☐ Bruise easily