Tanner Foot & Ankle Clinics

PATIENT HISTORY FORM

Patient's Name: _____Today's Date: _____ Date of Birth: _____

How did you hear about us (circle): Yellow Pages, Radio, Doctor, Patient, Internet, Other: _____

History of Present Illness

Reason for your visit today: _____

What do you think the problem is? _____

Are there specific treatments you would like to try? _____

Is this a result of an injury? _____ Has this been reported? ____ (ER, Job, Police, Legal, Workers Comp)

Onset of problem: _____

Previous Problems: _____

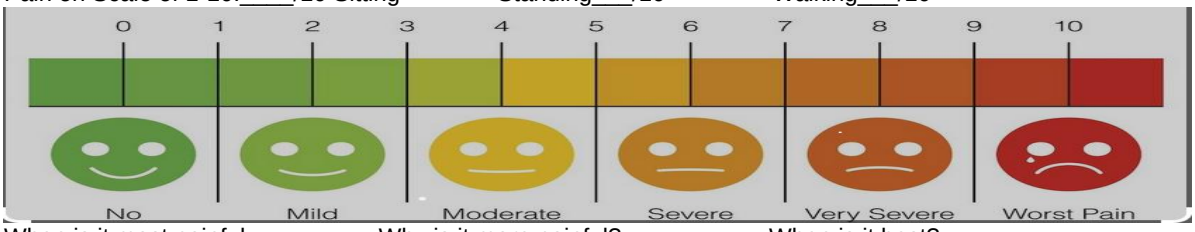
Treatments tried already (circle): Rest, Ice, Elevation, Tylenol, Ibuprofen, Bandage, inserts, Orthotics, Physical therapy, Seen other providers for this problem/Whom_____

_____

Describe the pain_____ Describe the area_____

Does the pain (circle): Travel Stay local Other:_____

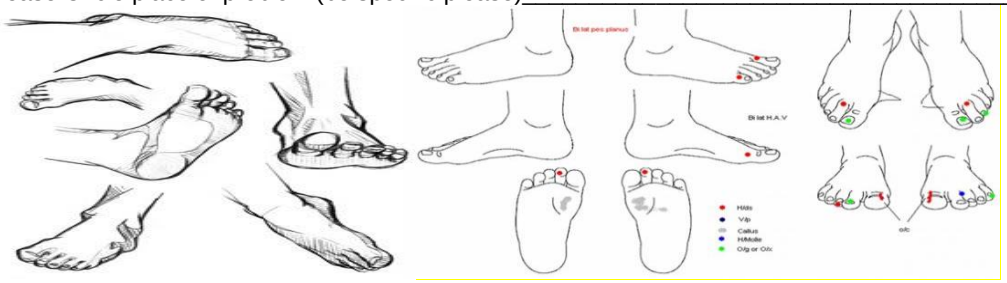
Pain on Scale of 1-10:____/10 Sitting Standing___/10 Walking___/10



When is it most painful_____Why is it more painful?_____When is it best?:_____

Anything else you have also noticed? _____

Please Circle place of problem (be specific please)_____



Past Medical History

Primary Care Physician's name & Location: _____Date of last exam:_____

Have you ever been hospitalized? ☐Yes ☐No If yes, what for? _____

Do you currently feel sick? Yes No. If yes describe symptoms:_____

Conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease / Murmur / Angina ☐ Breathing Disorder ☐Eye disorder / Glaucoma ☐Diabetes-HgA1c:___

☐High cholesterol ☐Asthma ☐Seizures ☐Kidney / Bladder problems ☐High blood pressure

☐Lung problems ☐ cough ☐Stroke ☐Liver problems / Hepatitis ☐Low blood pressure ☐Sinus problems

☐Headaches / Migraines ☐Arthritis ☐Heartburn (reflux) ☐Seasonal allergies ☐Neurological problems

☐Cancer ☐Anemia or blood problems ☐ Poor Blood Flow ☐Tonsillitis ☐Depression / Anxiety

☐Ulcers/colitis ☐Swollen ankles ☐Ear problems ☐Psychiatric care ☐Thyroid problems

Please describe any current or past medical treatment not listed above

_____

Please list your past surgeries and year performed: _____

_____

Did you have any problems with (circle): Anesthesia, Bleeding, Healing, Scarring, Medications, Other:_____

Over

What other specialists have you seen in the last 5 years?:

Whom	Reason	Treatments performed
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Are you allergic to any of the following (circle): Penicillin Sulfa drugs Betadine Iodine dye Certain Metals Latex Adhesives Others-Please list:_____

_____

Medications -Include Prescriptions, Over the counter medications and, supplements, etc. If you have a copy of your medications already please circle (photocopy) and attach so we can make a copy instead.

Name of:	Dose:	When taken:

Do you currently smoke or chew tobacco? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No

How many packs per day? _____ How many years?:_____

Do you drink alcohol, beer, or wine? ☐Yes ☐No How many drinks per week? _____

Do you currently drink coffee and/or tea? ☐Yes ☐No If yes, how many cups per day?_____

Do you exercise daily/weekly? ☐Yes ☐No If yes what?_____

Employment Conditions: [ ] Sits at Job [ ] Stands at Job [ ] Stands & Walks at Job [ ] Retired

Job Title:_____ Sexually transmitted disease? ☐Yes ☐No Diagnosis: _____

Family History

Living Age (or age at death) List serious illnesses

Mother ☐Yes ☐No _____

Father ☐Yes ☐No _____

Sisters ☐Yes ☐No _____

☐Yes ☐No _____

Brothers ☐Yes ☐No _____

☐Yes ☐No_____

Is there any chance you may be pregnant (circle): Yes No If yes, tell Dr Oaks when present as well.

By signing below, I hereby certify that the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ **Date** _____