

PAST MEDICAL HISTORY (continued)



Free Foot & Ankle Clinic, PC
3740 Eastlake Centre
Quincy, IL 62301

Please check all that apply:

	Never	Past	Present	
<input type="checkbox"/> diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> weight loss (more than 3lbs. per week)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> conjunctivitis (blood shot eyes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> back problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> skin rash or other skin problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> heart condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	which joint _____
<input type="checkbox"/> lung condition or shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> stomach or bowel problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> hepatitis or other liver problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	describe location _____
<input type="checkbox"/> circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> ears/nose/mouth/throat problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please list any present or past medical condition not mentioned above: _____

PAST FAMILY AND SOCIAL HISTORY: HAVE ANY FAMILY MEMBERS BEEN DIAGNOSED WITH:

Condition	Relationship	Condition	Relationship
<input type="checkbox"/> diabetes	_____	<input type="checkbox"/> HIV positive	_____
<input type="checkbox"/> high blood pressure	_____	<input type="checkbox"/> cancer	_____
<input type="checkbox"/> heart disease	_____	<input type="checkbox"/> rheumatoid arthritis	_____
<input type="checkbox"/> lung disease	_____	<input type="checkbox"/> gout	_____
<input type="checkbox"/> tuberculosis	_____	<input type="checkbox"/> other family disease	_____
<input type="checkbox"/> thyroid	_____		_____

Activity level: (Please check all that apply)

- on feet all day
- walk ___ miles per day/week
- mostly sitting
- aerobics: ___ step ___ hrs/wk
- on rough ground
- run ___ miles per day/week
- on concrete
- low impact ___ hrs/wk
- up and down
- high impact ___ hrs/wk
- golf ___ holes/wk
- climbing/jumping
- other

As with all information the following is strictly confidential:

Alcohol consumption: How many drinks? ___ daily ___ weekly ___ monthly rarely never
 Tobacco: I smoke ___ pack(s) per day for ___ years smokeless tobacco ___ times per day cigar/pipe ___ times per day
 Recreational Drugs: _____
 Other information which you feel may be helpful to the doctor in evaluating your condition: _____

I authorize the release of any medical or other information necessary to process this claim. I verify the above information to be an accurate representation of my medical condition and history to the best of my knowledge, and consent to the administration of treatment deemed necessary for the diagnosis and treatment of my foot/ankle condition.

Signature

Date

Parent or Guardian