Advanced Foot & Ankle Center
Piedmont HealthCare

Medical History

Patient Name: ______________________________ Primary Care Physician: ______________________

Date of Birth: ________________ Date Last Seen by PCP: ______________________

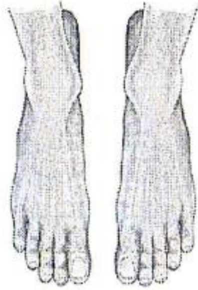
Pharmacy Name/Location: ____________________

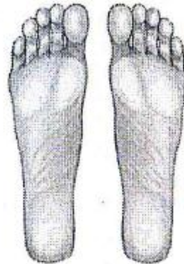
Reason for Today's Visit: *(please check all that apply)*

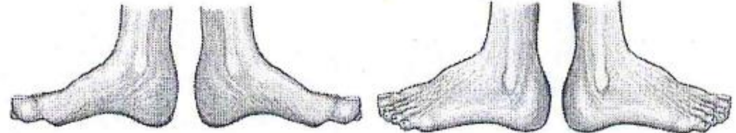
☐ Pain ☐ Swelling ☐ Numbness ☐ Deformity ☐ Other: __________________________________

Please circle the area of concern:

Right **Left** **Right** **Left** **Right** **Left** **Left** **Right**







How long have you had this problem: ______ Symptoms are: ☐ Improving ☐ Worsening ☐Unchanged

Describe your pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Tingling ☐Other: ________________

Symptoms are worse when: ☐ Standing ☐ Walking ☐ Running ☐ Other: ______________________

Symptoms are worse: ☐ Morning ☐ Evening ☐ Night ☐ All Day

Previous treatments include: ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Shoe Inserts ☐ Injections ☐ Brace/Bandage
☐ Surgery ☐ Medications ☐ Other: ______________________________

Have you been previously treated for this condition by another physician: ☐ Yes ☐ No

Allergies: *(please list)* ____

Medications: *(please list)*

Name of Medicine Dosage What is it for?

____

____

____

____

____

____

Have you ever been treated for any of the following? *(Please check below)*

☐ Diabetes	☐ Heart	☐ Stroke	☐ Arthritis	☐ Anemia	☐ High Blood Pressure
☐ Gout	☐ Hemophilia	☐ Asthma	☐ Ulcers	☐ Thyroid	☐ COPD
☐ Seizures	☐ Stomach	☐ Anxiety	☐ Nerves	☐ Cancer	☐ High Cholesterol
☐ Liver	☐ Back Pain	☐ Lupus	☐ Blood Clots	☐ Tumors	☐ Bleeding Disorder
☐ Hepatitis	☐ Circulation	☐ Kidney	☐ Bladder	☐ HIV +	☐ Mental Disease
☐ RA	☐ Pacemaker				

Social History:

Height: ______ Weight: ______ Shoe Size: ______

Pregnant: ☐Yes ☐No Claustrophobic: ☐Yes ☐No Metal in Body: ☐Yes ☐No Welder: ☐Yes ☐No

Do you drink Alcohol:: ☐Yes ☐No How much?: ________

Do you Smoke: ☐Yes ☐No Packs per day?: ______ ☐ Former smoker ☐ Everyday smoker ☐ Never smoked

Medical History

Additional Medications:

Name of Medicine	Dosage	What is it for?

Surgeries/Hospitalizations: *(Please list)*

Type (circle one)	Year	Surgery Name or Reason for Hospitalization
☐ Surgery / Hospitalization ☐		
☐ Surgery / Hospitalization ☐		
☐ Surgery / Hospitalization ☐		
☐ Surgery / Hospitalization ☐		

Injury: ☐ Yes ☐ No (*If yes, please complete the following*)

Date of Injury: ____________________

How did injury occur?: (Please be as detailed as possible)

If Work Comp Related:

Employer Name: ____________________

Employer Phone: ____________________

Employer Address: ____________________

Administrator Name: ____________________