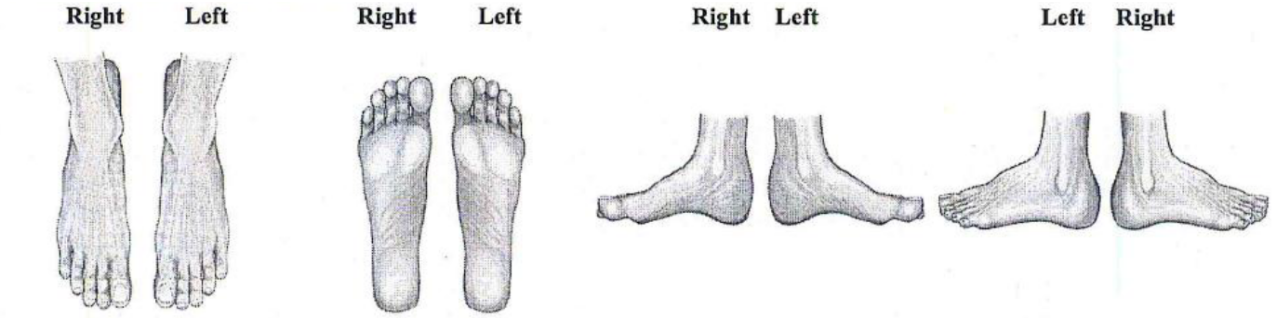
MRN: _____

Piedmont HealthCare
Advanced Foot & Ankle Center

Patient Medical History Form

Patient Name: _____ Primary Care Physician: _____
Date of Birth: _____ Date Last Seen by Primary:_____
Pharmacy Name/Location:_____

Reason for Today's Visit: *(Please check all that apply)*
☐ Pain ☐Swelling ☐ Numbness ☐Deformity ☐ Nails trim ☐ Other:_____



How long have you had this issue: _____ 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: *(Please check all that apply)*
Have you seen another physician for this condition? ☐ Yes ☐ No
Prior Treatments Include: ☐ Rest ☐ Elevation ☐ Ice ☐Heat ☐Shoe Inserts ☐Injections ☐Brace/Bandage
☐ Surgery ☐ Medications ☐ Other: _____

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 all that apply)*

Please see reverse side

□ 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 (Rheumatoid Arthritis)		□ Pacemaker			

Social History:

Height: _____ Weight: _____ Shoe Size: _____ Pregnant: □ Yes □No Claustrophobic: □ Yes □No
Metal in Body: □ Yes □ No Welder: □ Yes □ No Drink Alcohol?: □ Yes □ No How much: _____
Do you Smoke: □ Yes □ No Packs per Day? _____ □ Former smoker □ Everyday smoker □ Never smoked

Surgeries/Hospitalizations: *(Please List, when and what)* **ONLY LIST LAST 5 YEARS**
□ Surgery / Hospitalizations □ : _____
□ Surgery / Hospitalizations □ : _____
□ Surgery / Hospitalizations □ : _____
□ Surgery / Hospitalizations □ : _____

Injury: □ Yes □ No (*If yes, please complete the following)*
Date of Injury: _____

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

Is this a Worker's Compensation Claim? □ Yes □ No

*RECEPTION BE NOTIFIED AT FIRST APPOINTMENT – WE DO NOT PARTICIPATE WITH SOME WORK COMP INSURANCES – FAILURE TO NOTIFY US MAY RESULT IN YOUR CLAIM BEING DENIED**

If Work Comp related:
Employer Name: _____
Employer Phone: _____
Employer Address: _____
Adjuster/Case Manager: _____
Phone #: _____ Fax #: _____
Date of Injury: _____ Claim Number: _____