Salt Lake City Podiatry
Podiatry Foot and Ankle Surgery

Health History

PATIENT NAME:_____ DATE OF BIRTH:_____ DATE:_____

Height:_____ Weight:_____ Occupation: _____ ❑ Retired ❑ Student

Preferred Pharmacy: _____ Pharmacy Location: _____

History of Present Illness: Primary Physician: _____

Chief Complaint: _____

- **Location** _____
  Where is the pain/problem?
- **Severity** _____
  How severe is the pain/problem on a scale of 1-5? (5 being the most severe)
- **Timing** _____
  Does this pain/problem occur at a specific time?
- **Duration** _____
  How long have you had this pain/problem? Or when did it start?

ROS (for Physician to review)

❑ Constitutional Symptoms	❑ Cardiovascular
❑ Eyes	❑ Ears, Nose, Mouth, Throat
❑ Allergic	❑ Respiratory
❑ Gastrointestinal	❑ Genitourinary
❑ Musculoskeletal	❑ Integument
❑ Neurological	❑ Psychiatric
❑ Hematological	❑ Endocrine

Describe pertinent positives _____

❑ **All others Negative**

❑ **NO known allergies** **ALLERGIES:** _____

PATIENT MEDICAL HISTORY:

Diabetes	❑ No	❑ Yes
Hypertension	❑ No	❑ Yes
Cancer	❑ No	❑ Yes
Stroke	❑ No	❑ Yes
Heart Trouble	❑ No	❑ Yes
Arthritis/Gout	❑ No	❑ Yes
Convulsions	❑ No	❑ Yes
Bleeding Tendency	❑ No	❑ Yes
Acute Infections	❑ No	❑ Yes
Venereal Disease	❑ No	❑ Yes
Hereditary Defects	❑ No	❑ Yes

PREVIOUS HOSPITALIZATIONS / SURGERIES / SERIOUS INJURIES: **When?**

_____
_____
_____
_____

MEDICATIONS/DOSAGE:

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

PATIENT SOCIAL HISTORY:

Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Use of Alcohol ❑ Never ❑ Rarely ❑ Moderate ❑ Daily If yes: ❑ Beer ❑ Wine ❑ Hard Alcohol

Smoking Status ❑ Never ❑ Former smoker ❑ Current some days
❑ Current every day _____ packs/day ❑ Chews tobacco

Use of Drugs ❑ Never ❑ Type/Frequency: _____

Excessive exposure at home or work to: ❑ Fumes ❑ Dust ❑ Solvents ❑ Air-borne particles ❑ Noise

FAMILY MEDICAL HISTORY:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Patient/Responsible Party Signature: _____ **Date:** _____

Reviewed By/Physician Signature: _____ Date: _____

Physician Use Only: Smoking Cessation: ❑ Discussed ❑ Education given ❑ Reviewed