

Midwest Orthopedic Foot & Ankle, P.C.
PAST MEDICAL HISTORY

Name: _____ Age: _____ Date: _____

List all past operations: _____ Year: _____ Outcome: _____

| Do you have a history of: | | Review of Symptoms: | | Describe Positive Responses: |
|---------------------------|--|------------------------|--|------------------------------|
| Heart Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | Lungs, Breathing | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> | Stomach Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> | High Blood Pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Bleeding Ulcer | Yes <input type="checkbox"/> No <input type="checkbox"/> | Bleeding/Clot Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Blackout/Fainting | Yes <input type="checkbox"/> No <input type="checkbox"/> | Eyes | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Epilepsy | Yes <input type="checkbox"/> No <input type="checkbox"/> | Ears, Nose, Throat | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Digestion/Stomach | Yes <input type="checkbox"/> No <input type="checkbox"/> | Bowel Movement | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Rheumatoid Arthritis | Yes <input type="checkbox"/> No <input type="checkbox"/> | Bladder Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Polio | Yes <input type="checkbox"/> No <input type="checkbox"/> | Numbness/Tingling | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| TB | Yes <input type="checkbox"/> No <input type="checkbox"/> | Balance Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| AIDS | Yes <input type="checkbox"/> No <input type="checkbox"/> | Psychological Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |

List all medications you are currently taking:
 Medicine: _____ Dose: _____ Frequency: _____ For what illness: _____

Any other medical illnesses: _____

List any allergies to medications or food and adverse reactions:

Do you smoke? ___ Yes ___ No # of cigarettes per day _____

Do you drink alcohol? ___ Yes ___ No # of drinks per week _____

Height _____ Weight _____

Has any family member had a history of serious illness? _____ Yes ___ No

If yes, please describe _____

Who referred you (Referring Physician)? _____

Reason for Visit: _____

Is this an Injury? _____ Date of Injury: _____ Work Related? _____ Auto Related? _____

Are you off work due to injury? _____ If yes, for how long? _____

Has any member of your family been seen in our Office before? _____

If yes, who? _____

Marital Status ___ Single ___ Married ___ Divorced ___ Widowed (Check One)

Occupation: _____ If retired, previous occupation: _____

How long have you worked there? _____

Physician's Signature: _____