Tanner Foot Clinics PATIENT HISTORY FORM

Patient's Name: Today's Date:				
Date of Birth:				
How did you hear about us (circle): Yellow Pages, Radio, Doctor				
Patient Internet: Google/Bing/Firefox/Yahoo Other:				
May we contact you by email for appointment reminders and helpful foot information [] yes [] no.				
Email address:				
<u>History of Present Illness</u>				
Reason for your visit today:				
Onset of problem: Days , Weeks, Months, Years ago.				
Previous Problems:				
Treatments tried already (circle): Rest, Ice, Elevation, Tylenol, Ibuprofen, Ace, Bandage, Arch Support,				
Orthotics, Bracing, Pain Medications, Padding, Sugery, Other:				
Describe the pain Sharp, Shooting, Burning, Stabbing, Tingling, Tight				
Full, Dull, Pounding, Aching, Throbbing, Numb, Superficial, Deep.				
Does the pain (circle): Travel/Radiates Stays local Other:				
Pain on Scale of 1-10: /10 Sitting Standing /10 Walking /10				
Vhen is it most painful When is it best:				
Anything else you have also noticed?				
Location: Please Circle place of problem: Right Left Both Leg Ankle Foot Toes: 1(big) 2 3 4				
Old programu				
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part and burner was an end				
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a Casas Organ				
Past Medical History				
Primary Care Physician's name & Location:				
Date of last exam: Have you ever been hospitalized? □Yes □No If yes, what for?				
Trave you ever been nospitalized: 11es 11vo ii yes, what for:				
Do you currently feet sick? Yes No. If yes, describe symptoms:				
Conditions are you currently being treated or have been treated for in the past (please check)				
General: Health (good fair poor) weight change (elevated/decreased intentional? Yes/No), fevers, chills,				
sweats, fatigue, heat/cold intolerance.				
Skin: rash, itching, dryness, ulcers, color change, skin cancer, hair loss, nail changes				
respiratory: cough, sputum, short of breath, cough up blood, wheezing, asthma.				
Cardiovascular: chest pain, edema, palpitations, irregular heartbeat, painful legs with elevation.				
Abdominal: poor appetite, heartburn, regurgitation, nausea, vomit, abdomen pain, bloating, diarrhe				
constipation, hemorrhoids, blood in stool				
Urinary: Painful urination, incontinence, blood in urine, erectile dysfunction, enlarged prostate.				
MSK: joint pain (hands/elbow/shoulder/hips/knees/feet) swelling, a.m. stiffness, back pain, cramps,				
fractures, weakness, fatigue.				
Hematologic: sickle cell thalassemia, pallor, orthostasis, easy bleeding/bruising, history of transfusion,				
lymphadenopathy, blood thinner usage.				
Neurologic: headache, weakness, seizure, head trauma, loss of consciousness, numbness,				
dizziness, confusion, memory loss, difficulty walking, tremor, incoordination, back pain,				
adiating pain, history of carpal tunnel.				
Psych : anxiety, panic, and sadness, hopelessness, tearful, suicidal, depression, bipolar.				
Sleep : insomnia, snoring, sleep apnea. Nutrition(per day): 5 meals, 4 meals, 3 meals, 2 meals, 1 meal.				
erect. modifina, shoring, sleep aprica. Humilion(per day). Simeals, 4 meals, 5 meals, 2 meals, 1 meals.				

Medical History (Reasons you have seen a doctor/hospitalizations in the past) not listed above:

Please list your past surgeries and ye	ar performed:		Year	
Did you have any problems with (circle): Anesthesia, Bleeding, Healing, Scarring, Medications, Other:				
Allergies Are you allergic to any of the following (circle Latex Adhesives Others-Please list:	le): Penicillin Sulfa	drugs Betadine	e Iodine dye Certain Metals	
<u>Medications</u> -Include Prescriptions, Over the counter medications and, supplements'. If you have a copy of your medications already please circle (photocopy) and attach so we can make a copy instead.				
Name of:	Dose:	When taken:	Reason taken:	
Pharmacy:		Location:		
Do you currently smoke or chew tobacco? □Yes □No If no, have you in the past? □Yes □No How many packs per day? How many years?: Do you drink alcohol, beer, or wine? □Yes □No How many drinks per week? Do you currently drink coffee and/or tea? □Yes □No If yes, how many cups per day? Do you exercise daily/weekly? □Yes □No Type of Exercise Employment Conditions: [] Sits at Job [] Stands at Job [] Stands & Walks at Job [] Retired Current Job Title and what it entails: Have you had a sexually transmitted disease? □Yes □No Diagnosis: Is there any chance you may be pregnant (circle): Yes / No /Unsure Family History List serious illnesses Mother: Father				
Other: By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate. Patient/Legal Guardian Signature Date				