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Appalachian Foot and Ankle Associates
Patient Health History

Patient Name _____ **Date** _____ **ID#** _____

Chief Complaint _____

(Specific reason for your visit)

Describe pain or discomfort *(circle)* Burning Throbbing Sharp Dull Aching Numbness Tingling Shooting

How intense is your pain? 0 = none, 10 = severe *(circle)* 0 1 2 3 4 5 6 7 8 9 10

Condition has existed for _____ days _____ weeks _____ months _____ years
Is condition due to an accident/injury? Yes No Date of accident /injury _____
If yes, is it work related? Yes No How accident/injury occurred _____

Name of your primary care physician(s) _____
Are you currently under his/her care? ***Yes No*** If Yes, for what? _____
May we contact your Physician(s), Pharmacies, Hospital(s) for your health records? ***Yes No***

_____

Do you have or have you had any of the following:

Office Use:
HT:_____
Wt:_____
Pulse:_____
BP:_____
SO02:_____
Temp:_____
Shoe Size:_____
Measure:
RT_____
LT_____

___Prone to Infection	___Toe Nail Problems	___Polio
___Cancer	___High Blood Pressure	___Asthma
___Diabetes	___Foot or Leg Swelling	___Anemia
___AIDS or HIV+	___Lupus	___Gout
___Hepatitis	___High Cholesterol	___Fainting Spells
___Foot or Leg Injuries	___Thyroid Problems	___Bleeding Tendency
___Acid Reflux	___Fever, Chills, Night Sweats	___Blood Disease
___Stomach Ulcers	___Low Back Pain	___Circulation Problems
___Foot or Leg Cramps	___Liver Disease	___Fibromyalgia
___Foot or Leg Numbness	___Rheumatic Fever	___Varicose Veins/DVT
___Knee Pain	___Epilepsy	___Peripheral Neuropathy
___Unequal Leg Length	___Afib/Stent/Irreg. Heartbeat	___PVD
___Bunions	___Heart Surgery	___Other _____
___Foot Skin Problems	___Bursitis or Arthritis	_____

Family History of: Diabetes ***Yes No*** , Heart Disease ***Yes No*** , High Blood Pressure ***Yes No***

LIST ALLERGIES: _____

LIST CURRENT MEDICATIONS: (Include mg./dosage and any OTC products)

_____

List past surgical procedures: _____

Have you had previous treatment by a podiatrist? **Yes No** When? _____ For what? _____

Use of Alcohol.... ___ Never ___ Rarely ___ Moderate ___ Daily
Use of Tobacco.. ___ Never ___ Previously, but quit ___ Current Packs per Day
Use of Drugs..... ___ Never Type and Frequency _____

To the best of my knowledge these questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my health status. I hereby give Appalachian Foot and Ankle Associates, Dr. Costanzo, Dr. Rehm and/or Dr. Szypczak permission to perform the necessary services I may need.

X _____
Signature of patient, parent, guardian or power of attorney