Name _____ DOB _____ Date _____

HEALTH HISTORY FORM

Age_____ How would you rate your general health? Excellent Good Fair Poor

REASON FOR TODAYS VISIT:_____

REVIEW OF SYMPTOMS: Please check all current symptoms you have.

Constitutional
___ Recent fever/sweats
___ Unexplained weight loss/gain
___ Unexplained fatigue/weakness

Respiratory
___ Cough/Wheeze
___ Coughing up blood

Skin
___ Rash
___New or change in mole
___Itching
___Dry skin

Eyes
___ Change in vision
___Blurred vision

Gastrointestinal
___Heartburn/reflux
___ Change or blood in bowel movement
___ Nausea/vomiting/diarrhea
___ Pain in abdomen

Neurological
___Headaches
___ Memory loss
___ Fainting

Ears/Nose/Throat/Mouth
___ Difficulty hearing/ringing
___Hay fever/allergies
___Trouble Swallowing

Genitourinary
___Painful/blood urination
___Frequent urination

Psychiatric
___Anxiety/stress
___Sleep problems

Cardiovascular
___Chest pain/discomfort
___Palpitations

Blood/Lymphatic
___ Unexplained lumps
___ Easy bruising/bleeding

Musculoskeletal
___ Muscle /joint pain
___ Recent back pain

Endocrine
___ Cold/heat intolerance
___ Increased thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? __yes __ no

MEDICATIONS: Prescription & non-prescription medicines, vitamins, herbs, ect. ____ Review list in Chart

Medication Dose Times per day

_____

_____

_____

_____

ALLERGIES or reactions to medications:_____

Primary Care Doctor: _____ **Date Last Seen:** _____

Other Doctors Seen: _____

How did you find out about Oconee Foot & Ankle?: _____

Shoe Size_____ Have you worn Diabetic or custom shoes ____yes _____no
If yes, when did you receive them_____
Do you get burning, tingling, or numbness in your feet or legs ____yes ____no
Do you get cramps in your legs after walking a short distance ____yes ____no
Do you suffer from cramps that wake you up at night ____yes ____no

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates)

___Heart disease ___Heart Attack, Date_____ ___Pacemaker ___Liver Disease ___MRSA infection

___High blood pressure ___ High cholesterol ___ Asthma/Lung disease ____Hepatitis _____HIV/AIDS

___ Diabetes ___Type ___Type 2 ___Number of Years What was your last A1C?_____

___Thyroid problems ___Kidney disease ___Dialysis ____Metal Implants in body

___Cancer (type)_____

___Other (specify) _____

SURGICAL HISTORY: Please list all prior operations or procedures with dates:

_____

_____

FAMILY HISTORY: Please indicate immediate family members with any of the following conditions

Alcoholism_____ High Cholesterol_____

Cancer, (type) _____ **High blood pressure _____**

Heart disease _____ **Stroke _____**

Depression/Suicide _____ Bleeding/Clotting disorder _____

Genetic disorder _____ Asthma/COPD _____

Diabetes _____ Foot Amputation_____

Other _____

SOCIAL HISTORY

Tobacco Use: ☐ **Never** ☐ **Quit date_____**

☐ Current smoker: packs /day _____ # of years_____

Are you interested in quitting? ____yes ____no

Alcohol Use

Do you drink Alcohol? ___Yes ___ No # of drinks per wk._____

Is your alcohol use a concern for you or others? ___Yes ___No

Drug Use

Do you/have you used any recreational drugs? ___Yes ___No

Have you ever used injectable drugs? ___Yes ___No

OTHER CONCERNS

Weight: Are you satisfied with our weight? ____Yes _____No

Diet: How do you rate your diet? ___ Good ____Fair ____ Poor

Do you exercise regularly ____Yes ____No

What kind of exercise? _____

Minutes per day _____ How often_____

Do you have a living will or durable power of attorney ____Yes ____No

Socioeconomics

Occupation_____ Employer _____

Education Highest degree _____ Marital Status: Single Married Divorced Widowed Other _____

Spouse/Partners' Name _____ # of Children _____

Who lives with you? _____