Oakton Foot and Ankle Center, PLLC

Steven R. Vetter, D.P.M.
Diplomate, American Board of Podiatric Surgery
Diplomate, American Board of Podiatric Orthopedics and Primary Podiatric Medicine

Address
10721 Main Street Suite 3500
Fairfax, Virginia 22030
(703) 352-8888 Fax (703) 352-8994

HEALTH HISTORY

Date: ______________________

Patient Name: ___________________________________ Age: ____________

Chief Complaint: ____

History of present illness:

Location: ___________________________________
Where is the pain/problem?

Type of Pain: ____
Ex: burning, tingling, achy,dull, sharp, shooting, stabbing, etc.

Severity: ___________________________________
How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?

Duration: _______________________________________
How long have you had this pain/problem? When did it start?

Timing: _____________________________________
Does the pain/problem occur at a specific time?

Context: _______________________________________
Where were you at the onset of this pain/problem?

Associated signs/symptoms:
____
____
What other associated problems have you been having?

Modifying factors:
____
____
What makes the pain/problem worse or better? Have you had previous episodes?

Past Medical History: Have you ever had any of the following: (Select "**yes**" or "**no**," leave blank if uncertain)

	Yes	No		Yes	No		Yes	No
Anemia			Foot Ulcer			Pacemaker		
Anorexia			Gastric Ulcer			Pneumonia		
Arthritis			Glaucoma			Polio		
Asthma			Heart Murmur			Prostate Problem		
Back Problems			Heart Disease			Psychiatric Care		
Bleeding Tendency/Disorder			Hepatitis – Type_____			Respiratory Disease		
Blood Disease			Hernia			Rheumatic Fever		
Cancer			Herpes			Scarlet Fever		
Chemical Dependency			HTN / High Blood Pressure			Sinusitis		
Chemotherapy			HIV / AIDS			SOB/Shortness of Breath		
Chicken Pox			Jaundice			Stroke		
Chronic Fatigue			Kidney Disease			Thyroid Disorder		
Circulatory Prob			Kidney Stones			Tonsillitis		
Congenital Heart			Liver Disease			Tuberculosis		
Cough			Low Blood Pressure			Veneral Disease		
Diabetes Type I			Measles			Any Other :		
Diabetes Type II			Migraines			Child Birth		
Eczyma/ Skin Rash			Mitral Valve Prolapse			Pregnancies #_____		
Emphysema			Multiple Sclerosis			Live Births # _____		
Epilspsy			Mumps			Miscarriages # _____		

Additional Explanation of Medical History:

____

____

Physicians Currently Treating You:

____

____

Past Surgical History (Your Previous Operations):

Type	Year	Reason
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

ALLERGIES: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of: ___Yes ____No If Yes, Please Explain: ____

____

Additional Allergies:

Check box that applies:	No	Yes	If yes, what happens?
Penicilln			
Other antibiotics			
Morphine			
Codeine			
Demerol			
Other Narcotics			
Novocaine			
Other Anesthetics			
Aspirin			
Empirin, Tylenol			
Advil, Aleve or Motrin			
Other pain remedies			
Sulfa drugs			
Adhesive tape			
Neosporin			
Shrimp, Iodine or Merthiolate			
Any other drugs or medications: Please List:			

Current Medications (Including non-prescriptions):

Medication	Dosage	Frequency
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Social History:

Marital Status	Single: ☐	Married: ☐	Separated: ☐	Divorced: ☐	Widowed: ☐
Use of Alcohol	Never: ☐	Rarely: ☐	Moderate ☐	Daily: ☐	
Use of Tobacco	Never: ☐	Previously, but quit: ☐	Date quit: ___________	Current packs/day:	
Use of Drugs	Never: ☐	Type:	________________	Frequency:	
Excessive exposure at home or work to:	Fumes: ☐	Dust: ☐	Solvents: ☐	Airborne particles: ☐	Noise: ☐

Family Medical History: Please check if any members of your family (mother, father, grandparents, siblings or children) have had any of the following:

DISEASE	**Mother** Alive/Deceased	**Father** Alive/Deceased	**Siblings**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**	**Other**
Anemia								
Asthma								
Diabetes **Type I / Type II**								
Emphysema/COPD								
MI								
High Blood Pressure								
Liver Disease								
Stroke								
Kidney Disease								
High Cholesterol								
Cancer **Type:**								

Review of Symptoms:
As you review the following list, please check any problems that you have or have had in the past.

General	Cardiovascular	Endocrine
▢Recent weight loss/gain ▢Amount _________ ▢Fatigue ▢Fever ▢Chills ▢Weakness ▢Night sweats	▢Chest pain ▢Irregular heart beat ▢Palpitations ▢Waking short of breath ▢Heart murmur ▢Ankle/Leg swelling ▢Leg pain with walking ▢Pacemaker/defibrillator If yes, what company? ___________________________	▢Excessive thirst ▢Heat/cold intolerance ▢Diabetes ▢Thyroid disease
Neuro ▢Headache ▢Dizziness ▢Fainting ▢Numbness/tingling ▢Seizures ▢Stroke ▢Tremors	GI ▢Indigestion/heartburn ▢Abdominal pain ▢Nausea ▢Rectal bleeding ▢Vomiting of blood or coffee-ground material ▢Dark or bloody stools ▢Constipation ▢Diarrhea	Musculoskeletal ▢Joint pain ▢Muscle pain ▢Muscle weakness ▢Back pain
Eyes ▢Eye pain/pressure ▢Loss of vision ▢Blurred vision ▢Double vision	GU ▢Difficulty urinating ▢Pain or burning on urination ▢Blood in urine ▢Getting up at night to urinate ▢Prostate problems	Integumentary ▢Rash ▢Hives ▢Itching ▢Hair loss on legs
ENT ▢Hearing loss ▢Ringing in ears ▢Nose bleeds ▢Difficulty swallowing ▢Problem snoring/Sleep apnea ▢Hoarseness	Heme/Lymphatic ▢Swollen glands ▢Bleeding disorders ▢ Easy bruising ▢Anemia	Psychiatric ▢Anxiety ▢ Panic attacks ▢Depression
Respiratory ▢Shortness of breath ▢Wake short of breath ▢Cough ▢Coughing up blood ▢Wheezing ▢Difficulty breathing when lying flat		

My signature verifies that the information provided is correct to the best of my knowledge (if completed by someone other than the patient, please indicate name and relationship to the patient).

Patient Signature ____ **Date**_____________

Other Signature____ **Date**_____________

Relationship to Patient____

Signature Financially Responsible Party Date