Thunderbird Internal Medicine Patient History Form- Podiatry

Patient Name: _____ **Date of Birth:** _____

New Chief Complaint: _____

Location: _____ **Date of Onset:** _____

Symptoms: _____

_____

Onset: ☐ Gradual ☐ Sudden Duration: _____D☐ W☐ M☐ Y☐

Pain Assessment- Severity ☐ Mild ☐ Moderate ☐ Severe **Night Cramps:** ☐ Yes ☐ No

Quality of Pain ☐ Sharp ☐ Dull ☐ Tingling ☐ Shooting ☐ Throbbing ☐ Aching

Pain in: ☐ AM ☐ PM ☐ Constant ☐ Intermittent

Pain with shoes: ☐ ON ☐ OFF ☐ Both **Aggravated by activity:** ☐ YES ☐ NO

Patient Weight: _____ **Shoe Size:** _____ **Occupation:** _____

Previous Treatment: _____

YES	NO	Circle those that apply & Write in others
☐	☐	**Eye, Ear, Nose Throat Problems:** Glaucoma, Lens Implants, dentures, loose teeth, dental caps, bridges, hearing aids, glasses, contacts, or artificial eye.
☐	☐	**Heart Problems:** Chest Pain, angina, heart attack, congestive heart failure, Irregular heart beats, Pacemaker.
☐	☐	**Vascular Problems:** high blood pressure, Blood clots
☐	☐	**Lung Problems:** asthma, emphysema, Tuberculosis, Coughing, Cough up blood, abnormal chest x-ray Sleep Apnea
☐	☐	**Gastrointestinal Problems:** Hepatitis, Cirrosis, Ulcers, Hiatal Hernia, Intestinal Bleeding
☐	☐	**Genitourinary Problems:** OB/Gyn, Kidney disease Kidney Failure, Prostrate Problems, Incontinence, Sexually transmitted Disease, Infections
☐	☐	**Muskuloskeletal Problems:** Back pain, broken bones, Limited Range of Motion, Arthritis, TMJ
☐	☐	**Skin Problems:** Rash, Hives, bruise easily, open Sores
☐	☐	**Neurological Problems:** Seizures, Paralysis/Numb Areas, Stroke, Weakness, Migraines, Confusion
☐	☐	**Mental Illness:** Anxiety, Depression, Bipolar Disorder
☐	☐	**Endocrine Problems:** Diabetes, Thyroid **if diabetic, controlled by:** ☐ Diet ☐ Oral Agent ☐ Insulin

YES	NO	Circle those that apply & Write in others
☐	☐	**Is there any possibility you could be pregnant?** ☐ **LMP** ☐ **Birth Control**
☐	☐	**Do you have Anemia or Unusual Bleeding?**
☐	☐	**Cancer?** _____ _____
☐	☐	**A bad reaction to Anesthesia? Describe.** _____ _____
☐	☐	**Past Surgeries, Procedures, Illnesses, or hospitalization births:** _____ _____ _____
☐	☐	**Allergies:** _____ _____ _____
☐	☐	**Medications: (or attach list):** _____ _____ _____
☐	☐	**Tobacco: ____ppd Quit Date: _____**
☐	☐	**Alcohol: _____# per day _____How often?**
☐	☐	**Illicit Drugs: _____what? _____IV Use?**

X _____

Patient/Guardian Signature **DATE**