Bozeman Foot and Ankle Clinic, P.C.
COMPREHENSIVE HEALTH REVIEW

Patient Name: _____ Date of Birth: _____

HISTORY OF PRESENT ILLNESS/ WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

_____

_____

When did the problem begin? _____

The problem is: ☐ Improving ☐ Worsening ☐ Unchanged

What aggravates the problem? _____

Which foot / ankle is involved? ☐ Right ☐ Left ☐ Both

First visit to a doctor for this problem? ☐ Yes ☐ No

Have you had a similar problem in the past? ☐ Yes ☐ No

How was the problem onset? ☐ Sudden ☐ Gradual

The problem is worst: ☐ AM ☐ PM ☐ At Rest ☐ With Activity

What improves the problem? _____

Is the problem painful? ☐ Yes ☐ No if so, rate your current pain: **(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)**

Describe the Pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Cramping ☐ Itching ☐ Popping

☐ Burning ☐ Tingling ☐ Clicking ☐ Shooting ☐ Stabbing ☐ Other: _____

Describe previous treatments: _____

Have any tests been done? ☐ X-Rays ☐ CT Scan ☐ MRI ☐ Labs ☐ None Where: _____

Is this from an injury? ☐ Yes ☐ No If so, Is it work related? ☐ No ☐ Yes If so, how: _____

MEDICATIONS (INCLUDE RX MEDS, OTC MEDS, AND VITAMINS)

Medication	*Dosage*	*Medication*	*Dosage*

Preferred Pharmacy: _____ **City**: _____

Primary Care Physician: _____

ALLERGIES & REACTIONS

☐ None
☐ Adhesives / Tape
☐ Aspirin
☐ Codeine
☐ Cortisone
☐ Iodine
☐ Latex
☐ Local Anesthetics
☐ Penicillin
☐ Seafood / Shellfish
☐ Sulfa Drugs
☐ Other _____

_____

PAST MEDICAL HISTORY

If yes, check box. If no, leave blank.

☐ Diabetes Type 1 or 2 Duration: _____ Years, Last Blood Sugar _____mg/dl HbA1c:_____%

☐ Acid Reflux
☐ Anemia
☐ Anesthesia Complications
☐ Arthritis (☐ Osteo / ☐ Rheum)
☐ Asthma
☐ Back Problems / Sciatica
☐ Blood Clot / DVT
☐ Cancer: _____
☐ Cellulitis / Skin Infection ☐ MRSA?
☐ Circulation Problems
☐ Dementia / Alzheimer's
☐ Excessive / Easy Bleeding
☐ Fibromyalgia
☐ Foot / Leg Ulcer
☐ Gout
☐ Healing Problems / Keloids
☐ Heart Disease / Heart Attack
☐ High Blood Pressure ☐ Low BP?
☐ High Cholesterol
☐ Hormone Therapy
☐ Immune Disorder / HIV
☐ Kidney Disease (☐ Dialysis)
☐ Liver Disease (☐ Hepatitis)
☐ Leg Cramps / Leg Pain at Rest
☐ Lung Condition: _____
☐ Mitral Valve Prolapse / Murmur
☐ Multiple Sclerosis
☐ Nervous Disorder / Depression
☐ Neuropathy
☐ Osteomyelitis / Bone Infection
☐ Parkinson's Disease
☐ Previous Addiction to: _____
☐ Pulmonary Embolism
☐ Rashes / Skin Condition
☐ Raynaud's Disease / Phenomenon
☐ Seizure Disorder / Epilepsy
☐ Sickle Cell Disease / Trait
☐ Sleep Apnea (☐ on CPAP?)
☐ Stomach Ulcers
☐ Stroke ☐ RT ☐ LT (Year ___)
☐ Thyroid Condition (☐ HI ☐ LO)
☐ Varicose Veins
☐ Women- are you pregnant or breast feeding?

Continued on Back

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY (Circle Relative)

Mother **F**ather **S**ister **B**rother **G**rand**P**arent

☐ Cancer	M F S B GP
☐ Diabetes	M F S B GP
☐ Gout	M F S B GP
☐ Heart Disease	M F S B GP
☐ High Blood Pressure	M F S B GP
☐ Arthritis	M F S B GP
☐ Foot Problems	M F S B GP
☐ Other: _____	M F S B GP

PAST SURGERIES

☐ Foot/Ankle Surgery: ☐ RT / ☐ LT _____
☐ Joint Replacement: ☐ RT / ☐ LT _____
☐ Open Heart / Bypass Surgery / Pacemaker Placement
☐ Stent Placement: Heart / Leg
☐ Cosmetic Surgery: _____
☐ Appendix ☐ Gallbladder ☐ Tonsils
☐ Leg Bypass ☐ Open Fracture Repair
☐ Carotid Surgery ☐ Vein Surgery
☐ Hernia Repair ☐ Thyroid ☐ Back Surgery
☐ Other: _____

SOCIAL HISTORY

Occupation: _____
☐ I Drink Alcoholic Beverages how much / often: _____
☐ I Use or Have Used Tobacco Products Type: _____
Packs / Day _____ Years _____ When Stopped?: _____
☐ I Use or Have Used Illicit Drugs? Type: _____
I live with: ☐ No One ☐ Spouse ☐ Children ☐ Parents ☐ Other

I Stand _____ % of my Day
I Exercise Each Week: ☐ 0 days ☐ 1-2 Days ☐ 3+Days
List Sports/Activities: _____
_____
My foot/ankle problem limits my activities? ☐ Yes ☐ No
I am: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Widowed

STATS

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

REVIEW OF SYSTEMS *Symptoms you are currently experiencing*

CONSTITUTIONAL
☐ Recent Weight Change
☐ Gain ☐ Loss
☐ Fatigue
☐ Fever / Chills

NEUROLOGICAL
☐ Dizzy Spells / Fainting
☐ Numbness
☐ Tingling
☐ Seizures
☐ Weakness
☐ Paralysis / Tremors

RESPIRATORY
☐ Shortness of Breath
☐ Chronic / Frequent Cough
☐ Wheezing

CARDIOVASCULAR
☐ Chest Pain
☐ Palpitations
☐ Arrhythmia / Irregular Heart Beat
☐ Leg Pain when Walking
☐ Swelling of Hands / Feet

EARS/NOSE/MOUTH/THROAT
☐ Hearing Loss
☐ Ringing in Ears
☐ Nose Bleeds
☐ Sore Throat / Voice Changes
☐ Sinus Problems
☐ Difficulty Swallowing

ENDOCRINE
☐ Hormonal Problems
☐ Excessive Thirst
☐ Excessive Sweating
☐ Too Hot / Too Cold

EYES
☐ Vision Changes
☐ Cataracts
☐ Blurred or Double Vision
☐ Glaucoma
☐ Blindness

GASTROINTESTINAL
☐ Indigestion / Heartburn
☐ Diarrhea
☐ Nausea or Vomiting
☐ Stomach Pains

HEMATOLOGICAL
☐ Bruise Easily
☐ Slow to Heal
☐ Anemia
☐ Past Transfusion

INTEGUMENTARY
☐ Rash or Itching
☐ Dry Skin
☐ Changes in Hair / Nails
☐ Color Changes
☐ Ulcers
☐ Lumps
☐ Sores

MUSCULOSKELETAL
☐ Muscle Pain or Cramps
☐ Joint Pain
☐ Stiffness / Swelling of Joints
☐ Back Pain
☐ Trouble Walking
☐ Gout

PSYCHIATRIC
☐ Anxiety
☐ Depression
☐ Confusion / Memory Loss

The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care.

X _____ _____

Patient / Guardian Signature ***Date***

Bozeman Foot & Ankle Clinic, P.C.

Legal Name: (Last, First, M.I.) _____ Prev. Last Name: _____

Nickname: _____ Date of Birth: ____/____/____ SSN: _____ ☐ MALE ☐ FEMALE

Physical Address, City, State, Zip: _____

PO Box / Sec. Address, City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ May We Send Information Here? ☐ YES ☐ NO

Preferred Pharmacy: _____ City: _____ State: _____

Consent to Request Medication History From Your Pharmacy? ☐ YES ☐ NO

Your Employer: _____ Occupation: _____ Years There: _____
Employer's Address, City, State, Zip: _____
Work Phone: _____ May We Contact You at Work? ☐ YES ☐ NO

Name of Spouse/Partner: _____ Date of Birth ____/____/____
SSN: _____ Their Employer: _____
Employer's Address, City, State, Zip: _____
Employer's Telephone: _____ Years Employed There: _____

In Case of an Emergency, Contact: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

1) **Preferred Language**: ☐ English ☐ Spanish ☐ Other _____
2) **Race:** ☐ White ☐ African American ☐ Asian/Pacific Islander ☐ Native American/Alaskan ☐ Latin American ☐ Decline to Specify ☐ Other _____
3) **Ethnicity:** ☐ Hispanic/ Latino ☐ NON Hispanic/ Latino ☐ Declined to Specify

A COPY OF YOUR INSURANCE CARD IS REQUIRED; PLEASE PRESENT THOSE CARDS TO THE RECEPTIONIST

Insurance Company: _____
Policy Number: _____ Group Number: _____
Subscribers Name: _____ DOB: ____/____/____ SSN: _____
Relationship to Patient: _____ Employer: _____

Do you have a secondary insurance? ☐ YES ☐ NO

Insurance Company: _____
Policy Number: _____ Group Number: _____
Subscribers Name: _____ DOB: ____/____/____ SSN: _____
Relationship to Patient: _____ Employer: _____

COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE

Responsible Party: _____ Relationship to Patient: _____
DOB: ____/____/____ SSN: _____ Employer: _____
Employers Address, City, State, Zip: _____
Home Address, City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____
How Did You Hear About Our Practice? _____