MidAmerica Orthopaedics
Trusted Experts Where Healing Matters

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## HEALTH HISTORY

Foot/Ankle Complaint: _____ Date of Symptoms: _____

Accident Related? Yes ___ No ___ If Yes, Please Explain: _____

Height: _____Weight: _____ Shoe Size: _____ Do you or have you ever worn custom foot orthotics? Yes ____ No ____

Rate Your Health: Excellent___ Good ____ Fair ____ Poor ____

Primary Care Physician: _____ Phone: _____

Last Seen: _____ Reason: _____

Are you now, or have you been under a Physician or Specialist care during the past two years? Yes ____ No ____

Reason/Condition: _____

Please list all of the medications you are taking:

MEDICATIONS: DOSAGE: FREQUENCY:

_____

_____

_____

_____

_____

_____

_____

Are you ALLERGIC to any medications? YES ____ NO ____ If yes, what _____

Are you ALLERGIC to anything else? YES ____ NO ____ If yes, what _____

Do you SMOKE? YES ____ NO ____ If yes, how much _____ packs/day_____ years

Do you drink ALCOHOL? YES ____ NO ____ If yes, how much (daily/social) _____

Have you fallen in the past year YES ____ NO ____ Has it resulted in an injury? YES ____ NO ____

**Do you or a blood relative have a history of any of the following:**

| | | | | |
|---|---|---|---|---|
| Heart Condition | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Hypertension | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Diabetes | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Liver Problems | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Anemia | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Arthritis | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Kidney Problems | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Gout | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Cancer | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Epilepsy | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Vertigo | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Fainting | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Asthma | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |
| Other | Self? ◯ | Family? ◯ | Who in Family: | N/A ◯ |

_____ _____

**Patient Signature** **Date**