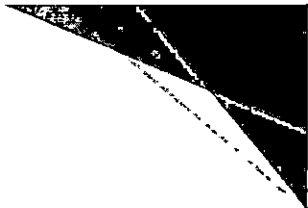


BENENATI FOOT AND ANKLE CARE CENTERS
HISTORY AND PHYSICAL

PATIENT NAME:____________________________________ Date:_______________

CHIEF COMPLAINT: What brought you to the doctor today?

____

Describe pain: _________________________Severity of pain on scale 1-10__________

How long has this been present: ____

PAST MEDICAL HISTORY: Do you have a history of any of the following:

Hypertension Diabetes Stroke Nervousness Tumors DVT

Heart/Circulation Trouble Hypoglycemia Emphysema Epilepsy Cancer Gout

Glaucoma Kidney Disease Ulcers HIV/AIDS Asthma Anemia

Liver Disease Arthritis Hepatitis Leg Cramps Tuberculosis

Thyroid Disease Varicose Veins Cholesterol Bleeding Tendencies

Other____

GENERAL HEALTH: Good Fair Poor Height ____________Weight_________

Past Surgical History Have you had any surgery before Yes No

If yes, please list procedure and
dates____

____

ALLERGIES: Do you have any allergies to medications? Yes No

Penicillin Sulfa Codeine Aspirin Novocain Tetracycline

Cipro Tetanus Anesthetics Antihistamines Eggs Nuts

Other

Are you allergic to latex products? Yes No

MEDICATIONS: List all prescription medications you take, include dosage and frequency. Insulin, inhaler and patches should be included here.

____

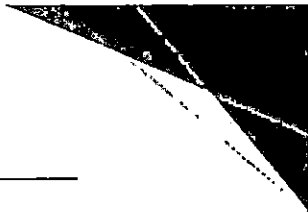
____

____

List all non-prescription medication you take routinely

____

____



BENENATI FOOT AND ANKLE CARE CENTERS

Name____ Date__________________

Social History

Do you smoke Yes No How Much per Day?

Do you drink alcohol Yes No How much?

What type of job do you have? ____

Family History Do any illnesses run in your family

Mother____

Father____

Siblings____

Review of Systems Please **circle** if you have any of the following:

CONSITUTIONAL
Fever
Weight loss
Lethargy

EARS, NOSE, MOUTH & THROAT
Tinnitus
Nose bleeds
Nasal congestion
Sore throat
Difficulty swallowing

GENITOURNINARY
Frequency
Blood in urine
Abnormal urine color
Painful urination
Awaken to urinate
Unable to fully empty bladder
Incontinence
On Hemodialysis

HEMATOLOGIC/LYMPHATIC
Easy bruising
Anemia
Blood abnormalities
Blood thinners
Lymph node
Enlargement

EYES
Blurred vision
Cataracts
Glasses

RESPIRATORY
Chronic cough
Wheezing
Emphysema
Cough blood
Asthma

MUSCULOSKELETAL
Pain
Limited range of Motion
Limited strength
Arthritis
Foot deformity

NEUROLOGICAL
Headache
Headache
Fainting
Dizziness
Memory loss
Numbness
Tingling

ENDOCRINE
Night sweats
Thyroid disease
Diabetes

CARDIOVASCULAR
Shortness of breath
Chest pain (angina)
Heart palpitations
Heart attack
Stroke
Cold extremities
Hypertension
Calf pain
Low extremity swelling

GASTROINTESTIONAL
Pain
Diarrhea
Blood in stool
Constipation
Mucus in stool
Nausea
Vomiting
Vomit blood
Heartburn
Change in stool
Food intolerance
Loss of appetite

INTEGUMENTRY
Rash
Itching
Dry skin
Calluses
Fungal Nails
Ingrown toenail
Open lesion or Lumps