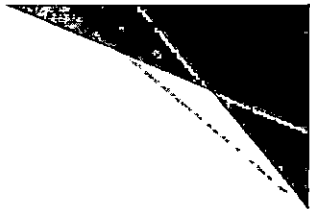


**BENENATI FOOT AND ANKLE CARE CENTERS
HISTORY AND PHYSICAL**



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



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:

CONSTITUTIONAL

- Fever
- Weight loss
- Lethargy

EARS, NOSE, MOUTH & THROAT

- Tinnitus
- Nose bleeds
- Nasal congestion
- Sore throat
- Difficulty swallowing

GENITOURINARY

- 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

- Seizures
- 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

GASTROINTESTINAL

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

INTEGUMENTRY

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