OK Foot MD
ORTHOPEDIC SPECIALISTS

Patient Name: _____

Date of Birth: _____ Chart #: _____

PATIENT HISTORY FORM (please completely fill this form out)

Height: _____ Weight: _____ Sex: ☐M ☐F Hand Dominance: ☐Left ☐Right ☐ Ambidextrous

MEDICAL STAFF USE ONLY: **Encounter: ☐Initial ☐Subsequent ☐Sequelae**

BMI: _____ BP: _____/ _____ Temp: _____ Pulse: _____ Resp: _____ Pulse Ox: _____

CHIEF COMPLAINT TODAY: ☐Left ☐Right ☐ Bilateral Body Part (s): _____

FOR INJURIES ONLY: **Date of injury: _____**

Describe **how** and **where** the injury occurred:_____

Did injury occur **on the job**? ☐Y ☐N

Did injury occur in an **auto accident**? ☐Y ☐N

If yes what **STATE** did the injury occur? _____ If yes to on the job **EMPLOYER** name:_____

Referring Physician/ Source: _____

Who is your Primary Care Physician? _____/ City, State/ Ph#: _____

Do you have a Cardiologist? ☐Y ☐N Physician Name: _____/ City, State, Ph#: _____

Do you have any other Specialists? ☐Y ☐N Physician Name: _____/ City, State, Ph#: _____

What is the reason for your visit today? _____

_____

Have you been to the emergency room or seen another physician/ provider prior to your visit today? ☐Y ☐N

Have you had previous? ☐ X-rays ☐ MRI ☐ CT SCAN ☐ DEXA ☐ Other _____

Describe your pain: ☐Achy ☐Burning ☐Sharp/ Shooting ☐Throbbing ☐Other:_____

What makes the pain worse? _____What makes the pain better? _____

What is your pain level on a scale of 1-10? _____

What treatments or modalities have you tried? (i.e. medications, injections, physical therapy, etc.)

_____

Social History: ***Marital Status:*** **☐Single ☐Married ☐Divorced ☐Widowed**

☐Current Every Day Smoker **☐Former Smoker**
☐Current Some Day Smoker **☐Never Smoker**

Do you drink alcohol? ☐Y ☐N If yes, how much?
☐0-1 drinks/day ☐1-2 drinks/day ☐3 or more/day

Type of Tobacco _____

Are you employed? ☐Y ☐N Are you retired? ☐Y ☐N

☐Cigarettes **☐Chewing Tobacco**
☐Cigars **☐Vapor/ E-Cigarettes**
☐Pipe **☐Snuff/ Smokeless Tobacco/ Other**

Type of Occupation? _____
Do you use or ever used illicit drugs? ☐Y ☐N
If yes, type/ frequency? _____

☐ Marijuana medical card

Do you have or have you ever had any of the following medical conditions:

******Any unchecked boxes will be assumed negative*****

☐ ***None of the below***

☐ **Abnormal Chest X-ray**
☐ **AIDS**
☐ **Anemia**
☐ **Anticoagulant Therapy**
☐ **Anxiety**
☐ **Arthritis, Osteoarthritis**
☐ **Arthritis, Rheumatoid**
☐ **Asthma**
☐ **Atrial Fibrillation**
☐ **Blood Disorders**
If yes type of blood disorder? _____
☐ **Cancer** ***If yes type of***
Cancer:_____
☐ **Cerebral Palsy?**
☐ **Chronic Obstructive Pulmonary Disease**
☐ **Congestive Heart Failure**
☐ **Deep Vein Thrombosus (blood clots)**

☐ **Depression**
☐ **Diabetes**
If yes ☐ Type I ☐ Type II
Date of last HbgA1C/ result _____/ _____
☐ **Eczema**
☐ **Emphysema**
☐ **Epilepsy**
☐ **Esophageal Reflux**
☐ **Eyesight problems**
☐ **Gallbladder Disease**
☐ **Glaucoma**
☐ **Gout**
☐ **Headache**
☐ **Heart Attack**
☐ **Heart Disease**
☐ **Heartburn/ GERD**
☐ **Hepatitis Type**_____
High Blood Pressure ☐**Y** ☐**N**
☐ **High Cholesterol**
☐ **HIV Infection**
☐ **Hyperlipidemia**
☐ **Immunological Disorders**

☐ **Kidney Disease/ Dialysis**
☐ **Liver Disease**
☐ **Low Blood Pressure**
☐ **Mental Illness** ***If yes type of illness:*** _____
☐ **Migraines**
☐ **Multiple Sclerosis**
☐ **Muscular Dystrophy**
☐ **Neuro Illness**
☐ **Osteomyelitis**
☐ **Peripheral Vascular Disease**
☐ **Are you Pregnant?**
☐ **Prostate Problems**
☐ **Pulmonary Embolism**
☐ **Seizure Disorder**
☐ **Sickle Cell Anemia**
☐ **Sleep Apnea**
☐ **Stomach Ulcer**
☐ **Stroke**
☐ **Thyroid Disease**
☐ **Tuberculosis**

Other illness or conditions: _____

_____

Have you had a BONE DENSITY SCAN? ☐**Y** ☐**N If yes date or year of scan** _____
Where was the scan done? _____ **/ City or State** _____

List All Previous Surgery/ Procedures	Date/ Year of Surgery/ Procedure

Preferred Pharmacy (please list)_____ Phone #_____
Street and City_____

List All Current Prescription and Over-the-Counter Medications ☐ Check if **None**

Medication	Strength	Frequency	Medication	Strength	Frequency

List All Allergies and Reactions (include meds, food, latex) ☐ **No Known Allergies**

Medication/ Other	Reaction	Medication/ Other	Reaction

Date of last FLU shot? _____ ☐**Never** **Date of last PNEUMONIA shot?** _____ ☐**Never**

Family Medical History- Check all boxes that apply- *Please indicate: M= mother, F= Father, B= Brother, S= Sister*

Alcoholism ☐M ☐F ☐B ☐S	Heart Disease ☐M ☐F ☐B ☐S	Pulmonary Embolism ☐M ☐F ☐B ☐S
Autoimmune Disorder ☐M ☐F ☐B ☐S	High Blood Pressure ☐M ☐F ☐B ☐S	Rheumatoid Arthritis ☐M ☐F ☐B ☐S
Birth Defects ☐M ☐F ☐B ☐S	High Cholesterol ☐M ☐F ☐B ☐S	Seizure Disorder ☐M ☐F ☐B ☐S
Blood Disorders ☐M ☐F ☐B ☐S	Liver Disease ☐M ☐F ☐B ☐S	Stomach Disorders ☐M ☐F ☐B ☐S
Cancer ☐M ☐F ☐B ☐S	Lung Disease ☐M ☐F ☐B ☐S	Stroke ☐M ☐F ☐B ☐S
Diabetes ☐M ☐F ☐B ☐S	Kidney Disease ☐M ☐F ☐B ☐S	
Drug Abuse ☐M ☐F ☐B ☐S	Mental Illness ☐M ☐F ☐B ☐S	
Eye Disorders ☐M ☐F ☐B ☐S		

Review of Systems: Please check here if you are NOT experiencing any of the below symptoms: ☐

Please check all that apply. Any unchecked boxes will be assumed to be negative.

Musculoskeletal	Endocrine	Gastrointestinal	Skin
☐ Joint pain/ stiffness	☐ Excessive thirst	☐ Nausea/ vomiting	☐ Rashes
☐ Joint swelling	☐ Excessive urination	☐ Constipation	☐ Dryness
☐ Back pain	☐ Heat/ cold intolerance	☐ Diarrhea	☐ Open sores
☐ Difficulty walking			
Cardiovascular	☐ **Heme/ Lymph**	**Genitourinary**	**Neurological**
☐ Chest pain/ tightness	☐ Easily bruised	☐ Incontinence	☐ Headaches
☐ Irregular heartbeat	☐ Bleeds easily	☐ Frequent urination	☐ Tremors
☐ Swelling of legs/ feet	☐ Swollen lymph nodes	☐ Painful urination	☐ Confusion
Respiratory	**Constitutional**	**Ears, Nose, Throat, Mouth**	**Psychiatric**
☐ Oxygen use at home	☐ Fever/ chills	☐ Difficulty hearing	☐ Depression
☐ Cough	☐ Fatigue/ weakness	☐ Difficulty swallowing	☐ Anxiety
☐ Wheezing	☐ Weight loss/ gain	☐ Dentures	☐ Nervousness
☐ Snoring		☐ Ringing in ears	
☐ Shortness of breath			

Completed by: (please print): _____ Date: _____

Patient/ Guardian Signature: _____ Date: _____

Relationship to Patient (please print): _____