Patient's Name: _____ DOB: _____

Patient History

All information is kept confidential. If you are uncomfortable answering any questions, leave them blank. You can discuss them with your doctor.

Chief complaint (What brings you to our office today?):

_____

_____

_____

General Medical History:

- ☐ Acid Reflux
- ☐ Alcohol/drug addiction
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder/blood clots
- ☐ Bowel problems
- ☐ Broken bones
- ☐ Cancer
- ☐ Chicken pox
- ☐ Collagen Vascular disease
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Gall bladder disease
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart disease/attacks
- ☐ Heart murmur
- ☐ Hepatitis/Liver disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Joint/back pain
- ☐ Kidney disease/stones
- ☐ Lung disease
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Seizures/epilepsy
- ☐ Sickle cell
- ☐ Stroke
- ☐ Thyroid disease – hypo/hyper
- ☐ Tuberculosis
- ☐ Ulcers/Acid Reflux
- ☐ Other: _____

_____

_____

Primary Care Physician: _____

Date Last Seen by Primary Care Physician: _____

Other Physician(s), i.e. for arthritis, diabetes, etc. _____

Stonebridge Foot & Ankle
181 N. Ridge Road, Ste. 200
McKinney, TX 75071

Patient's Name: _____ DOB: _____

Past Surgical History:

Date	Surgery

Medications (Please include any vitamins, herbs, supplements, or non-prescription drugs:

Drug Name **Dose**	**Drug Name** **Dose**

Pharmacy Name:_____ **Phone:**_____

Pharmacy Address:_____

Allergies: □None

Drug/Food/Other	**Reaction**

Social History:

Recent travel outside the U.S.? _____

Current or most recent job: _____

Patient's Name: _____ DOB: _____

Marital Status: □Married □Divorced □Single □Widowed □Living with partner

Smoking history: □Never smoked □Currently Smoke _____Cigarettes/Day for _____Years

□Previously smoked _____Cigarettes/Day for _____Years Quit_____

Alcohol history: □Never use □Occasionally □Socially _____drinks/day _____drinks/week

Do you currently use recreational drugs?: □Yes □No What drugs?_____

Family History:

Anyone in your family (grandparents, parents, brothers, sisters, etc.) with any medical problems:

Immunizations:

Date	Immunization	Date	Immunization
	Tetanus-Diphtheria Booster		Flu Shot
	Pneumoccocal Vaccine		Hepatitis B Vaccine
	Varicella Vaccine		Measles-Mumps-Rubella Vaccine

Review Of Systems:

Constitutional: □Change in appetite □Change in height □Difficulty sleeping □Fatigue □Fever □Weight loss □Weight gain □Night sweats □Other: _____

Eyes: □Double vision □Blurred vision □Glasses/contacts □Spots before eyes □Vision changes □Other:_____

Ears, Nose, Throat: □Congestion □Difficulty swallowing □Earaches/Ear infections □Hearing Problems □Mouth sores □Neck Stiffness/Pain □Nose bleeds/bleeding gums □Ringing in ears □Runny nose □Seasonal allergies □Sinus problems □Sore throat □Other:_____

Patient's Name: _____ DOB: _____

Cardiovascular: □Chest pain or pressure □Leg pain □Leg swelling
□Rapid or irregular heart rate □ Varicose veins □Difficulty breathing with lying flat
□Difficulty breathing with exertion □Other: _____

Respiratory: □Chronic cough □Coughing up blood □Painful breathing □Shortness of breath
□Wheezing □Difficulty breathing with lying flat □Difficulty breathing with exertion
□Other:_____

Gastrointestinal: □Abdominal pain □Acid reflux/heartburn □Black tarry stools □Bloody stools □Constipation □Diarrhea □Hemorrhoids □Incontinence □Indigestion □Jaundice
□Nausea/vomiting □Other:_____

Genitourinary: □Blood in urine □Frequent urination □Urinary incontinence □Frequent urinary tract infections □Pain with urination □Discoloration of urine
□Other:_____

Musculoskeletal: □Back pain □Joint pain □Joint stiffness □Muscle pain/cramps □Muscle weakness □Joint swelling □Redness or swelling of joints
□Other:_____

Skin: □Discoloration □Difficulty healing □Dry skin □Easy bruising □Itching □Moles
□Open wounds/sores □Rash □Other: _____

Neurologic: □Burning □Tingling □Numbness □Dizziness □Headaches □Seizures □Tremor
□Other: _____

Psychiatric: □Anxiety □Depression □Other: _____

Endocrine: □Abnormal hair growth □Abnormal thirst □Hair loss □Heat/cold intolerance
□Other:_____

Height:_____ Weight: _____ Shoe size: _____