



**Steven R Vetter, D.P.M**  
 DIPLOMATE, AMERICAN BOARD OF FOOT AND ANKLE SURGERY  
 DIPLOMATE, AMERICAN BOARD OF PODIATRIC MEDICINE

**Jugal R Dharia, D.P.M**  
 ASSOCIATE, AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS

10721 MAIN ST  
 SUITE #3500  
 FAIRFAX, VA 22030-6909  
 PHONE: 703-352-8888  
 FAX: 703-352-8994  
 www.oaktonfootanklecenter.com

**HEALTH HISTORY**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Age: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

**History of present illness:**

**Location:** \_\_\_\_\_

Where is the pain/problem?

**Type of Pain:** \_\_\_\_\_

Ex: burning, tingling, achy,dull, sharp, shooting, stabbing, etc.

**Severity:** \_\_\_\_\_

How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?

**Duration:** \_\_\_\_\_

How long have you had this pain/problem? When did it start?

**Timing:** \_\_\_\_\_

Does the pain/problem occur at a specific time?

**Context:** \_\_\_\_\_

Where were you at the onset of this pain/problem?

**Associated signs/symptoms:**

**Modifying factors:**

\_\_\_\_\_

\_\_\_\_\_

What other associated problems have you been having?

What makes the pain/problem worse or better? Have you had previous episodes?

**Past Medical History:** Have you ever had any of the following: (Select “yes” or “no,” leave blank if uncertain)

	Yes	No		Yes	No		Yes	No
Anemia			Foot Ulcer			Pacemaker		
Anorexia			Gastric Ulcer			Pneumonia		
Arthritis			Glaucoma			Polio		
Asthma			Heart Murmur			Prostate Problem		
Back Problems			Heart Disease			Psychiatric Care		
Bleeding Tendency/Disorder			Hepatitis – Type _____			Respiratory Disease		
Blood Disease			Hernia			Rheumatic Fever		
Cancer			Herpes			Scarlet Fever		
Chemical Dependency			HTN / High Blood Pressure			Sinusitis		
Chemotherapy			HIV / AIDS			SOB/Shortness of Breath		
Chicken Pox			Jaundice			Stroke		
Chronic Fatigue			Kidney Disease			Thyroid Disorder		
Circulatory Prob			Kidney Stones			Tonsillitis		
Congenital Heart			Liver Disease			Tuberculosis		
Cough			Low Blood Pressure			Veneral Disease		
Diabetes Type I			Measles			Any Other :		
Diabetes Type II			Migraines			Child Birth		
Eczyma/ Skin Rash			Mitral Valve Prolapse			Pregnancies # _____		
Emphysema			Multiple Sclerosis			Live Births # _____		
Epilpsy			Mumps			Miscarriages # _____		

Additional Explanation of Medical History:

---

---

Physicians Currently Treating You:

---

---

Past Surgical History (Your Previous Operations):

Type	Year	Reason
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

**ALLERGIES:** Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of: \_\_\_Yes \_\_\_No If Yes, Please Explain: \_\_\_\_\_

---

Additional Allergies:

Check box that applies:	No	Yes	If yes, what happens?
Penicillin			
Other antibiotics			
Morphine			
Codeine			
Demerol			
Other Narcotics			
Novocaine			
Other Anesthetics			
Aspirin			
Empirin, Tylenol			
Advil, Aleve or Motrin			
Other pain remedies			
Sulfa drugs			
Adhesive tape			
Neosporin			
Shrimp, Iodine or Merthiolate			
Any other drugs or medications: Please List:			



**Review of Symptoms:**

As you review the following list, please check any problems that you have or have had in the past.

<p><b>General</b></p> <input type="checkbox"/> Recent weight loss/gain <input type="checkbox"/> Amount _____ <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Night sweats	<p><b>Cardiovascular</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Palpitations <input type="checkbox"/> Waking short of breath <input type="checkbox"/> Heart murmur <input type="checkbox"/> Ankle/Leg swelling <input type="checkbox"/> Leg pain with walking <input type="checkbox"/> Pacemaker/defibrillator If yes, what company? _____	<p><b>Endocrine</b></p> <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Heat/cold intolerance <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease
<p><b>Neuro</b></p> <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremors	<p><b>GI</b></p> <input type="checkbox"/> Indigestion/heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Vomiting of blood or coffee-ground material <input type="checkbox"/> Dark or bloody stools <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea	<p><b>Musculoskeletal</b></p> <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Back pain
<p><b>Eyes</b></p> <input type="checkbox"/> Eye pain/pressure <input type="checkbox"/> Loss of vision <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision	<p><b>GU</b></p> <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Pain or burning on urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Getting up at night to urinate <input type="checkbox"/> Prostate problems	<p><b>Integumentary</b></p> <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Hair loss on legs
<p><b>ENT</b></p> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Problem snoring/Sleep apnea <input type="checkbox"/> Hoarseness	<p><b>Heme/Lymphatic</b></p> <input type="checkbox"/> Swollen glands <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Easy bruising <input type="checkbox"/> Anemia	<p><b>Psychiatric</b></p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Panic attacks <input type="checkbox"/> Depression
<p><b>Respiratory</b></p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wake short of breath <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty breathing when lying flat		

**My signature verifies that the information provided is correct to the best of my knowledge (if completed by someone other than the patient, please indicate name and relationship to the patient).**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Other Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

Signature Financially Responsible Party

Date