Aurora Foot & Ankle Surgical Specialists, LLC

Manx D. Quayle, DPM & David Huntsman, DPM

Medical History Form

Name: _____ **DOB:** _____ **Date:** _____

Reason for visit: _____

PLEASE COMPLETE THOROUGHLY. IF CONDITIONS DO NOT APPLY, PLEASE CIRCLE N/A.

PLEASE CIRCLE ALL THAT YOU HAVE BEEN TREATED FOR.

HEART: Chest Pain Palpitations Heart Failure Pacemaker
Irregular Heart Rate Valve Replacement Hypertension
High cholesterol Phlebitis Cellulitis Lymphedema
Coronary Artery Disease Bypass Surgery Catheterization
Angioplasty Stent Placement A-Fib **N/A**
Other: _____

LUNGS: Shortness of Breath Emphysema Pneumonia Asthma
Seasonal Allergies Pulmonary Embolism COPD **N/A**
Other: _____

GASTROINTESTINAL: Reflux Disease Hiatal Hernia Hemorrhoids
Abdominal Aortic Aneurysm Gallstones Gallbladder Removal
Appendectomy Colon Resection Hepatitis Bowel Incontinence **N/A**
Other: _____

NEUROLOGICAL: Stroke Brain Injury Migraines Head Injury
Intracranial Hemorrhage Herniated Disk Carpal Tunnel Sciatica
Limb Numbness/Tingling **N/A**
Other: _____

MUSCULOSKELETAL: Fractures Osteoarthritis Neck Pain
Rheumatoid Arthritis Osteoporosis Low Back Pain Scoliosis
Disc Disease Hip Replacement Knee Replacement **N/A**

Other: _____

ENDOCRINE: Diabetes Thyroid Problems **N/A**
Other: _____

MENTAL HEALTH: Depression Anxiety Panic Attacks
Bipolar Schizophrenia SAD **N/A**
Other: _____

CANCER: Location _____ **N/A**
Surgery: _____
Chemo: YES / NO Radiation: YES / NO

MEDICATIONS: **NONE** _____
_____
_____
_____
_____
_____

MEDICINE ALLERGIES: **NONE** _____
_____

SOCIAL HISTORY: Lives with: Spouse Parents Children Alone
Lives In: ___ Story House / Apartment / Townhouse / Mobile Home
_____ Steps In house. Ramp?_____ Elevator? _____
Bedroom and Bathroom on 1st floor? YES / NO
Smoking YES / NO _____Packs Per Day x___years
Alcohol YES / NO Daily or Socially?
Occupation: _____
_____Currently Working _____Not Working _____Retired

DO YOU NEED HELP WITH ANY OF THE FOLLOWING?

Getting in/out of bed?	YES_____	NO_____
Feeding Yourself?	YES_____	NO_____
Dressing Yourself?	YES_____	NO_____
Grooming Yourself?	YES_____	NO_____
Bathing Yourself?	YES_____	NO_____
Using the Restroom?	YES_____	NO_____
Getting in/out of Chairs?	YES_____	NO_____
Getting in/out of Shower?	YES_____	NO_____

DO YOU USE ANY OF THE FOLLOWING? *(PLEASE CIRCLE)*
Cane Wheelchair Walker Crutches Other

ARE YOU *CURRENTLY* EXPERIENCING ANY OF THE FOLLOWING? (*Please Circle all that apply)*

Fever Chills Weakness Insomnia Fatigue
Glasses Blurred Vision Double Vision Hearing Aid
Tinnitus Chest Pain Palpitations Shortness of Breath
Cough Nausea Vomiting Diarrhea Constipation
Incontinence Urinary Pain Urinary Burning Depression
Anxiety Rash Ulcerations Recent Surgical Wound
Swollen Glands Increased Bruising/Bleeding

FAMILY MEDICAL HISTORY: Please List Any Medical History That you are aware of for the following family members

Mother: _____ **N/A**
_____
Father: _____ **N/A**
_____
Siblings: _____ **N/A**
_____
Maternal Grandmother: _____ **N/A**
_____
Maternal Grandfather: _____ **N/A**
_____
Paternal Grandmother: _____ **N/A**
_____
Paternal Grandfather: _____ **N/A**
_____

For Office use only:
WT-_____HT-_____T-_____BP-_____P-_____R-_____