Maryland Foot & Ankle Restoration, LLC
Johny J. Motran, DPM
www.mfarestoration.com
HISTORY FORM

TODAYS DATE_____
Please fill out completely Location: Gaithersburg / Hyattsville

Patients full name:
Last_____First_____MI_____ Sex M F

Patient SS #_____ Date of Birth_____

Marital Status S M D W Name of Spouse _____

Phone_____Work_____Cel _____

Local Address_____

City_____ State_____ Zip_____

Second or out of state Address_____

City_____State_____Zip_____

Pharmacy # _____ E-Mail _____

Employer Name _____ Job Title _____

Company Phone _____ Address _____

_____

Name and **relationship** of Emergency Contact _____

Phone number of Emergency Contact _____

Name of Family Physician_____ Date last seen: _____

Phone_____ Fax_____

Address_____

_____ _____
SIGNATURE OF RESPONSIBLE PARTY DATE

Person responsible for services rendered if different than listed above

Name_____ SS#_____

Address_____

Phone_____ DOB _____

Please describe what brings you to the office today?

_____

_____

How would you describe your pain?

sharp aching throbbing shooting

electrical sensation pins and needles burning cramping numbness

Location of pain or primary complaint:

lower leg ankle Achilles tendon heel midfoot arch forefoot

sole of foot ball of foot top of foot big toe lesser toes toenails

other_____

How long has your problems been present?

1 – 3 days 3 – 7 days 1 – 3 weeks 3 – 6 weeks 6 – 8 weeks

3 – 6 months 6 – 9 months 9 – 12 months greater than 1 year

Onset of condition or injury:

gradual onset over time sudden onset from activity or injury

Course/progression of condition:

severe worsening moderate worsening mild worsening steady / unchanging

mild improvement moderate improvement considerable/good improvement

Pain / condition aggravated by:

any weight bearing standing walking running exercise bending stooping

pressure to ball of foot pressure from shoes pressure from jumping rubbing from clothing

Have you attempted any treatments to relieve your problem?

rest ice elevation change shoe gear over the counter padding

over the counter anti-inflammatory medication (Motrin, Aleve, Tylenol, Aspirin, etc)

in home whirlpool stretching

trimming out toenail yourself applying skin cream

applying topical antibiotic ointment (triple antibiotic, bacitracin, Neosporin, ext)

saw another physician for this problem – instructed to be seen in this office

treated for this condition by another physician

surgery for this condition by another physician

How much improvement and relief have you achieved with previous treatments?

mild improvement moderate improvement considerable improvement

no improvement worsening of condition

Additional factors

pain worse on 1st morning walking/activity

pain worse when standing and walking after rest

pain worse in shoes

pain worse with any movement

pain worse after running / exercise

pain worse after working on ladder

pain decreases after 1st 15 – 20 minutes of walking

pain decreases after rest

pain decreases after removing shoes

pain decreases after rubbing area

pain decreases after trimming out toenails, but returns in several days

Name of Primary Care / Family Physician?

First_____Last name _____

Date last seen by Primary Care / Family Physician

Month_____ day_____ and year_____ if known

How did you hear about our office ?

physician family/friend internet newspaper

phone book advertisement other _____

Constitutional: do you have:

fatigue weakness chills fever

weight loss greater than 10 pounds weight gain greater than 10 pounds

Head - Do you have:

dizziness fainting headache pain sweats

Nose - Do you have:

discharge bleeding infection obstruction

Mouth- Do you have: bleeding dentures dry mouth post nasal drip

Ears - Do you have:
hearing aids infections ringing

Throat/Neck - Do you have:
lumps tenderness hoarseness sore throat

Respiratory - Do you have:
asthma cough wheezing bronchitis pleurisy
shortness of breath COPD tuberculosis (TB)

Cardiovascular - Do you have:
chest pain varicose veins extremity(s) cool hair loss on legs
heart murmur high blood pressure rheumatic fever cramps in legs/feet
Myocardial Infarct/Heart attack leg or foot ulcers palpitations
replacement heart valve vascular grafts

Gastrointestinal - Do you have:
constipation diarrhea jaundice liver disease rectal bleeding
antacid use excessive thirst hepatitis (A, B, C) nausea swallowing problem
gall bladder disease heart burn hemorrhoids laxatives

Musculoskeletal - Do you have:
arthritis/degenerative joint disease joint pain gout lower back pain
knee pain back problems joint stiffness muscle cramps paralysis
restricted motion weakness ankle sprain arch pain broken ankle
broken foot bone bunions calluses childhood foot problems corns
flatfeet gait(walking) problems hammer/mallet toes heel pain high arch feet
in-toeing joint implants muscle stiffness neuroma orthotic use toe walking

Psychiatric - Do you have:
depression memory loss disorientation bipolar/schizophrenia

Integument - Do you have:
eczema itching warts dryness hives lumps athletes foot fungal nails ingrown nails keloid scars
mole changes rash

Neurological - Do you have:

burning fainting numbness speech disorders stroke(s)
tingling tremors unsteady gait black outs charcot neuroarthropathy
neuromas

Endocrine - Do you have:

diabetes weight gain weight loss fatigue goiter sweats thirst thyroid disease

Hematological -Do you have:

anemia bleeding easily blood clot bruise easily swollen glands
transfusion reaction slow healing cuts recent chemotherapy

Allergic/Immunologic-Do you have:

hives itchy eyes itchy nose runny nose sneezing stuffy nose
watery eyes wheezing swelling

Genitourinary - Do you have:

blood in urine burning excessive urination flank pain infections
retention urgency kidney stones hernia
venereal disease (Herpes, Chlamydia, Syphilis, Gonorrhea) HIV

Males: hernia prostate problems (male)
Females: birth control menopause recent pregnancy

Eyes - Do you have:

blurred vision cataracts contacts eye glasses
glaucoma eye infections

Medical History:

anemia arthritis asthma CAD (Coronary Artery Disease) cancer
CHF (Congestive Heart Failure) COPD high Cholesterol diabetes
epilepsy GERD (acid reflux) gout HIV hepatitis hypertension
stroke thyroid disease ulcer (GI)

Musculoskeletal - Do you have any of the following joint replacements/prosthesis:

hip knee ankle

hands feet spine

Date of joint replacement:

_____

Past medical history – injuries/trauma

_____

Have you had any of the following foot surgeries:

toenail bunion hammertoe fracture repair joint fusions

tendon repair/rerouting ankle stabilization arthroscopy fasciotomy

Please list approximate month and year of any surgery listed above:

_____

Past Surgical History: Have you had any of the following surgeries?

heart bypass heart valve repair/replacement appendectomy

gallbladder brain surgery other

Please list approximate month and year of any surgery listed above:

_____

Any other surgeries? (Please specify type of surgery and date)

_____

Any complications/problems with surgery or anesthetics? (please specify)

_____

Previous hospitalization - have you been admitted for:

heart attack stroke pneumonia cancer

infection injury other hospitalizations

Please list approximate month and year of any hospitalization listed above:

_____

Childhood Immunizations – have you been immunized for:

measles mumps rubella diphtheria tetanus

varicella zoster polio tuberculosis pneumonia flu

Family History - Father - Does/Did your father have:

Hypertension/high blood pressure CVA/stroke Diabetes

cancer circulation problems

Any other illnesses? (please list) _____

Is your father deceased? yes no

If your father is deceased - age and cause of death_____

Family History - Mother - Does/did your Mother have:

Hypertension/high blood pressure CVA/stroke Diabetes

circulation problems cancer

Any other illnesses? (please list) _____

Is your mother deceased? yes no

If your mother is deceased - age and cause of death_____

Family History Siblings - Does/Did your siblings have:

Hypertension/high blood pressure CVA/stroke Diabetes

circulation problems cancer

Any other illnesses? (please list) _____

Social History - Do you:

smoke tobacco smoke marijuana use hallucinogenic drugs

drink alcohol use cocaine use other recreational drugs

If you use other recreational drugs - please list/specify:

_____

Number of drinks per day?

1 2 3 4 5 greater than 5 per day 1 – 3/week 4 – 6 /week

Occasional use only social drinking only weekend drinking only

If you smoke, number of packs per day?

1/2 1 2 3 4 5 or more

1 -2/week 3 – 4/week occasional social weekends

Smoking status

Current everyday smoker current someday smoker former smoker for how long _____

never smoked Current status unknown unknown if ever smoked

Safety

Have you fallen in the last year? Yes No

Worries about falling when walking or standing? Yes No

Do you feel unsteady when walking or standing? Yes No

Women - Are you pregnant?

yes no

If pregnant, number of months:

_____

Medications - please list all medications (including aspirin) with **dosage** currently taking:

_____

_____

_____

_____

_____

Allergies - Do you have allergies to any of the following:

no known drug allergies <(please circle if no allergies)

drug allergies penicillin sulfa erythromycin

aspirin cortisone codeine adhesive tape

local anesthetics iodine latex

Other allergies to medications - please list severity and type of allergic response:

Mild moderate severe skin rash itching hives G I upset nausea vomiting diarrhea

Wheezing respiratory distress rapid pulse heart palpitations anaphylaxis

Do you have any **food** allergies - if so, please list:

_____

Do you have any allergies to **plants -** if so, please list:

_____

What is your height?

_____

What is your weight?

_____

What is your Shoe size and width?

_____

Vitals – What is your Pulse rate per minute? (only if you know your average value – otherwise leave blank) _____

Vitals – What is your most recent blood sugar level? (only if you are diabetic)

_____

Vitals – Blood pressure measured today by staff member: _____