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

TODAYS DATE_____
Please fill out completely

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

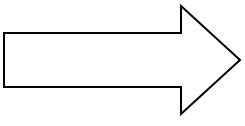
Person responsible for services rendered if different than listed above

Name_____ SS#_____

Address_____

Phone_____ DOB _____

Who can we thank for referring you?_____



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

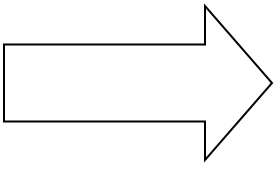
trimming out toenail yourself applying skin cream

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 when standing and walking after rest in shoes with any movement

after running / exercise after working on ladder

pain decreases:

after 1st 15 – 20 minutes of walking after rest after removing shoes after rubbing area

after trimming out toenails, but returns in several days

REVIEW OF SYMPTOMS:

Constitutional: do you have:

fatigue weakness chills fever weight loss greater than 10 pounds weight gain greater than 10 pounds

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 replacement heart valve

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 gait(walking) problems muscle stiffness

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:

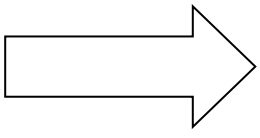
burning fainting numbness speech disorders stroke(s)

tingling tremors unsteady gait black outs neuromas

Hematological -Do you have:

anemia bleeding easily blood clot bruise easily swollen glands

transfusion reaction slow healing cuts recent chemotherapy



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:_____

Have you had any foot surgeries: _____

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)

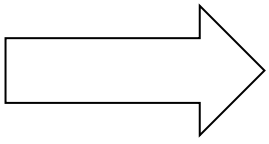
_____

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

_____

FAMILY HISTORY: Is there any family history (blood relative) of: (Please indicate family member)

Hypertension/high blood pressure _____
Blood Clot/stroke _____
Diabetes _____
Cancer _____
Circulation problems _____
Bleeding Disorders _____
Depression _____
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

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

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, **if** pregnant, number of months: _____

No

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

_____

_____

_____

_____

_____

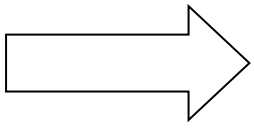
Allergies - Do you have allergies to any of the following:

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?

_____