

Dr. Johnny Motran, D.P.M., F.A.S.P.S
6505 Belcrest Road, Suite 1
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301-699-5900

MEDICAL HISTORY



Patient: _____ Date: _____

*****PLEASE ANSWER ALL QUESTIONS BELOW*****

What is your current foot problem? _____

How long has it bothered you? _____

Describe the quality of your pain: ☐ Burning ☐ Sharp ☐ Throbbing ☐ Aching ☐ N/A ☐ Other _____

Please circle the number that best describes the severity of your condition/pain?

0 1 2 3 4 5 6 7 8 9 10

No pain Mild pain Moderate Pain Severe Pain Worst Pain Imaginable

What are the signs and symptoms associated with your condition? Please check all that apply:

- | | | |
|--|---|--|
| ☐ Swelling of the foot and/or ankle | ☐ Drainage | ☐ Cramping |
| ☐ Numbness/Tingling | ☐ Dry or cracked skin | ☐ Joint pain |
| ☐ Difficulty Walking | ☐ Odor | ☐ Joint stiffness |
| ☐ Redness | ☐ Thickening of the nails | ☐ Muscle weakness |
| ☐ Warmth | ☐ Itching | ☐ Other: _____ |
| ☐ Bruising | ☐ Nausea/vomiting/Fever/Chills | _____ |

When does the condition bother you? Check all that apply:

- | | | |
|--|---|---------------------------------------|
| ☐ Constantly (All of the time) | ☐ During the day | ☐ Never |
| ☐ Intermittently (Sometimes/comes and goes) | ☐ In the evening | ☐ Other: _____ |
| ☐ In the morning | | _____ |

Has the condition been treated? ☐ Yes ☐ No If yes, how? _____

Is the condition getting ☐ Better or ☐ Worse?

What aggravates your condition?

- | | | |
|--|-----------------------------------|---------------------------------------|
| ☐ Shoes | ☐ Standing | ☐ Other: _____ |
| ☐ Walking/Running | ☐ Exercise | _____ |

What factors modify/relieve the condition?

- | | | |
|-------------------------------------|--|---------------------------------------|
| ☐ Rest | ☐ Soaks | ☐ Other: _____ |
| ☐ Ice | ☐ Wearing shoes | _____ |
| ☐ Elevation | ☐ Removing shoes | |
| ☐ Stretching | ☐ Skin lotion/creams | |
| ☐ Heat | ☐ Medication; Please list the medication: _____ | |

How did your condition present?

- | | | |
|--|--|--|
| ☐ Acute (Sudden onset) | ☐ Chronic (Slowly overtime) | |
| ☐ Insidious (Gradual Onset) | ☐ Other: _____ | |

Is there a history of foot and/or ankle conditions in the past? ☐ Yes ☐ No If yes, please explain:

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PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

- | | | |
|--|--|---|
| ☐ Diabetes Mellitus | ☐ Cancer. Specify type: _____ | ☐ List all others: _____ |
| ☐ High Blood Pressure | ☐ Epilepsy/Seizure disorder | |
| ☐ High Cholesterol | ☐ kidney disease | _____ |
| ☐ Heart Disease | ☐ Liver disease | |
| ☐ Gout | ☐ Circulation disorder | |
| ☐ Stroke | ☐ Asthma | |

MEDICATIONS (PLEASE BRING A LIST OF YOUR MEDICATIONS WITH THE DOSES FOR OUR OFFICE TO COPY)

List all current medications:

ALLERGIES (CHECK ALL THAT APPLY)

- | | | |
|---|--|------------------------|
| ☐ Penicillin | ☐ Codeine | List all others: _____ |
| ☐ Sulfa Drugs | ☐ Adhesive Tape | |
| ☐ Erythromycin | ☐ Latex | |
| ☐ Iodine/Shellfish | ☐ Novocain | _____ |
| ☐ Morphine | ☐ Aspirin | _____ |

PAST SURGICAL HISTORY (LIST ALL SURGERIES YOU HAVE EVER HAD IN YOUR LIFETIME)

SOCIAL HISTORY

- ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you currently pregnant or planning to become pregnant? ☐ Yes ☐ No ☐ N/A Are you breastfeeding? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

Are you a former smoker? ☐ Yes ☐ No If yes, when did you quit? _____ How many packs did you smoke per day? _____

If you are a former smoker, how long did you smoke? _____

Do you use alcohol? ☐ Never ☐ Rarely ☐ Socially ☐ Moderately ☐ Heavily

Do you have a history of alcoholism? ☐ Yes ☐ No If yes, see below and if no skip to next question.

Are you currently using alcohol? ☐ Yes ☐ No If no, how long have you been sober? _____

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MEDICAL HISTORY

Do you have a history of illegal drug use? ☐ Yes ☐ No If yes, which drug/drugs?

If you have a history of illegal drug use, are you currently using illegal drugs? ☐ Yes ☐ No
If no, when did you last use illegal drugs?

Do you have a history of addiction to prescription pain medication? ☐ Yes ☐ No If yes, which drug/drugs?

Are you currently taking prescription pain medication? ☐ Yes ☐ No
If no, when did you last use prescription pain medication?

FAMILY HISTORY (CHECK ALL THAT APPLY), *****Please indicate mother or father*****

M F ☐ HEART DISEASE M F ☐ GOUT M F ☐ KIDNEY DISEASE M F ☐ DIABETES M F ☐ HIGH BLOOD PRESSURE
M F ☐ PERIPHERAL NEUROPATHY M F ☐ STROKE M F ☐ LIVER DISEASE M F ☐ CANCER M F ☐ ARTHRITIS
M F ☐ List all others: _____

Patient: _____ Date: _____

REVIEW OF SYMPTOMS

PLEASE CHECK ALL THAT CURRENTLY APPLY

CONSTITUTIONAL SYMPTOMS

- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Fatigue

GENITOURINARY

- ☐ Dialysis
- ☐ Kidney Disease
- ☐ Kidney Stones

EYES

- ☐ Eye disease or injury
- ☐ Glaucoma
- ☐ Cataract
- ☐ Double vision/blurry vision

RESPIRATORY

- ☐ Productive cough
- ☐ Spitting up blood
- ☐ Wheezing

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Jaundice
- ☐ Diarrhea

PSYCHIATRIC

- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Muscle weakness

DERMATOLOGIC

- ☐ Rash
- ☐ Change in nails
- ☐ Non-healing wounds
- ☐ Dry and/or scaling skin

NEUROLOGICAL

- ☐ Frequent or recurring headaches
- ☐ Light-headed or dizziness
- ☐ Seizures
- ☐ Numbness or tingling sensations
- ☐ Paralysis

HEMATOLOGIC

- ☐ Anemia
- ☐ Bleeding/Bruising tendencies

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Foot or leg swelling

ENDOCRINE

- ☐ Excessive thirst
- ☐ Frequent urination
- ☐ Heat intolerance
- ☐ Cold intolerance

☐ NONE OF THE ABOVE APPLY AND I AM IN GENERAL GOOD HEALTH

Please list any other information you would like to share about your health:

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MEDICAL HISTORY

Height: _____

Weight: _____

Shoe size: _____

I have reviewed patient history and have made note of additional findings: _____

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