Dr. Johny Motran, D.P.M., F.A.S.P.S
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MEDICAL HISTORY

Maryland Foot & Ankle Restoration, LLC

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

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

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

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

Is the condition getting ☐ Better or □ Worse?

What aggravates your condition?

□ Shoes
□ Walking/Running
□ Standing
□ Exercise
□ Other: _____
_____

What factors modify/relieve the condition?

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

How did your condition present?

□ Acute (Sudden onset)
□ Insidious (Gradual Onset)
□ Chronic (Slowly overtime)
□ Other: _____

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

_____

_____

_____

Patient: _____ Date: _____

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.

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

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 (M) Mother or (F) 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
□ Chills
□ Weight loss
□ Weight gain
□ Fever
□ Fatigue

GASTROINTESTINAL
□ Nausea
□ Heart Burn/acid reflux
□ Hepatitis
□ Diarrhea

NEUROLOGICAL
□ Strokes
□ Unsteady Gait
□ Black Outs
□ Numbness or tingling sensations
□ Unsteady Gait

GENITOURINARY
□ Blood in Urine
□ Excessive Urination
□ Kidney Stones

PSYCHIATRIC
□ Depression
□ Disorientation
□Memory Loss

HEMATOLOGIC
□ Anemia
□ Bleeding/Bruising tendencies

EYES
□ Infections
□ Glaucoma
□ Cataract
□ Double vision/blurry vision

MUSCULOSKELETAL
□ Joint pain
□ Joint stiffness
□ Muscle weakness
□Walking Problems

CARDIOVASCULAR
□ Chest pain
□ Palpitations
□ Cramps in legs/feet
□ Hair loss on legs

RESPIRATORY
□ Cough
□ Short of Breath
□ Wheezing

DERMATOLOGIC
□ Rash
□ Fungal nails
□ Itching
□ Dryness

ENDOCRINE
□ Excessive thirst
□ Weight Gain
□ Weight Loss
□ Sweats

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☐ **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:

_____

_____

_____

_____

Height: _____

Welght:_____

Shoe size: _____

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

_____

Johny Motran, DPM