History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left ______________________________

____

2. **When did pain/discomfort begin (date):** ______________________________

Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other ____________________

3. **What makes the pain/discomfort better:** ______________________________

4. **Have you had a physical trauma?** ☐ No ☐ Yes ______________________________

5. **Have you had an accident?** ☐ No ☐ Yes ______________________________

6. **Occupation:** ____________________ **Is your problem work related?** ☐ Yes ☐ No

7. **Past Medical History:**

☐ Gout ☐ Thyroid Disorders ☐ Osteoarthritis
☐ Anemia ☐ Heart failure ☐ Lung/Respiratory Disorders ☐ Other Arthritis
☐ Bleeding Disorders ☐ Hepatitis ☐ Mitral Valve Prolapse ☐ Rheumatic Fever
☐ Cancer __________ ☐ High Cholesterol ☐ Nerve Disorders ☐ Stroke
☐ Diabetes ☐ HIV / AIDS ☐ Neurological Disorders ☐ Kidney Disease
☐ Epilepsy ☐ High Blood Pressure ☐ Prostate Disorders ☐ Other: __________

8. **List all medications/herbs/vitamins:** ☐ **NONE** ______________________________

____

9. **Allergies:** (Describe reaction) ☐ **NONE**

☐ Penicillin __________ ☐ Aspirin __________ ☐ Narcotic Agent / Codeine __________
☐ Anesthesia __________ ☐ Shellfish __________ ☐ Sulfa Drugs __________
☐ Nickel / Metal __________ ☐ Radiographic Contrast Dye __________
☐ Other ______________________________

10. **Are you currently pregnant?** __________ **Do you wear Glasses/Contacts?** __________

11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: ______________________________

____

12. **Social History:** (Only check what is pertinent to you)

☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits____________________
☐ Caffeine Use ☐ Drug use (recreational, IV)

13. **Family History: (List relationship of family member(s) who have had these problems):**

☐ Diabetes __________ ☐ Heart Disease __________ ☐ Kidney Disease __________
☐ Hypertension __________ ☐ Stroke __________ ☐ Mental Illness __________
☐ Rheumatology __________ ☐ Bleeding Disorders __________ ☐ Cancer __________
☐ Other family History: ______________________________

14. **Height:** __________ **Weight:** __________ **Shoe size:** __________ **Last Flu Vaccine**__________

For office use: B/P __________ Pulse __________ Resp. Temp

15. **Last Pneumonia Vaccine______________ A1C Test Result & Date Completed ____________________________**

NOTICE OF PRIVACY PRACTICES

Joseph C. Morgan, D.P.M. and Associates are committed to protecting the privacy and security of individual identifiable health information and other protected health information of a confidential nature for this medical practice as set forth in the health insurance portability and accountability act. (“HIPPA”)

I hereby acknowledge that I have read this “Notice of Privacy Practices.”

Patient signature: ____ Date: ___________

Witness signature:____ Date:___________

Permian Basin Foot & Ankle

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