

# Ford Center for Foot Surgery

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Medical History Form

Confidential

Patients Last Name: \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referred By: \_\_\_\_\_

What is the reason for your visit: check all that apply

	LFT	RGT		LFT	RGT
LEG	___	___	TOE(S)	___	___
ANKLE	___	___	NAILS	___	___
FOOT	___	___	SKIN	___	___

Quality of pain:

SORENESS	___	TINGLING	___
BURNING	___	THROBBING	___
NUMBNESS	___	SHARP/SHOOTING	___

Where is the pain?

TOP OF FOOT	___	HEEL	___
BALL OF FOOT	___	ARCH	___
TOE(S)	___	ANKLES	___

How long have you had the pain?

\_\_\_ Days      \_\_\_ Weeks      \_\_\_ Mnths      \_\_\_ Yrs

What helps/relieves the pain?

ICING \_\_\_      ELEVATING \_\_\_      MEDICATION \_\_\_

Past/Present Medical History:

Do you or a family member have any of the following:

	PT	FMLY		PT	FMLY
Anesthesia Rea.	___	___	High Blood Prs	___	___
Arthritis	___	___	HIV/AIDS	___	___
Cancer	___	___	Nerve Prob	___	___
Circulation Prob	___	___	Skin Prob	___	___
Diabetes	___	___	Heart Cond	___	___
Gout	___	___	Hepatitis	___	___

If diabetic, who is your treating doctor and when was your last visit

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What do your sugars average: \_\_\_\_\_

Do you have allergies to any of the following:

Penicillin \_\_\_\_\_ Keflex \_\_\_\_\_ Sulfa \_\_\_\_\_ Pain Meds \_\_\_\_\_

Anti Inflamm Med \_\_\_\_\_ Other \_\_\_\_\_

Do you smoke: no \_\_\_\_\_ yes \_\_\_\_\_ how many packs a day \_\_\_\_\_

Do you drink: no \_\_\_\_\_ yes \_\_\_\_\_ day \_\_\_\_\_ mo \_\_\_\_\_  
\_\_\_\_\_ rarely

List your medications:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

List Previous Surgeries:

Foot \_\_\_\_\_

Knee \_\_\_\_\_

Back \_\_\_\_\_

Hip \_\_\_\_\_

Do you experience:

- |  | Yes   | No    |
|--|-------|-------|
| 1. Swelling or cramping in legs or feet                      | _____ | _____ |
| 2. Unusually cold feet                                       | _____ | _____ |
| 3. Joint pain/bone pain                                      | _____ | _____ |
| 4. Knee, hip or low back pain                                | _____ | _____ |
| 5. Any skin problems or have any open sores                  | _____ | _____ |
| 6. Corns or calluses   | _____ | _____ |
| 7. Thick or ingrown toenails                                 | _____ | _____ |
| 8. Loss of strength in legs                                  | _____ | _____ |
| 9. Does Aspirin, Ibuprofen, Aleve etc.<br>upset your stomach | _____ | _____ |