West Seattle
Foot & Ankle Clinic

4520 42nd Avenue SW
Seattle, WA 98116
(206) 937-4700

Health History

Patient Name: _____

Primary Care Physician: _____ **Phone #** (___) ____-_____

May we contact your physician about your health? ☐ Yes ☐ No

Referring Physician: _____

Describe your current problem/complaint:

_____

_____

_____

MEDICATIONS

What medications are you currently taking? Please list all.

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Pharmacy: _____ **Phone Number:**_____

MEDICATION ALLERGIES

Medication Name	Reaction	Severity		
_____	_____	☐ Extreme	☐ Moderate	☐ Mild
_____	_____	☐ Extreme	☐ Moderate	☐ Mild

Do you have problems taking Aspirin/Motrin? ☐ Yes ☐ No

Any problems with local anesthetics? (Novocaine, Lidocaine)? ☐ Yes ☐ No

PAST MEDICAL/SURGICAL HISTORY

Have you had any past medical problems with your feet and ankles? Please explain:

_____

_____

Have you had any past surgeries on your feet and ankles? Please explain:

_____

_____

Have you had any serious illnesses? Please explain:

_____

_____

Please list any previous surgeries including date and physician's name:

_____

_____

_____

Check any of the following that you have, or have had a problem with and explain:

☐ Cardiovascular _____ ☐ Respiratory/Lungs _____

☐ Musculoskeletal _____ ☐ Psychiatric _____

☐ Endocrine _____ ☐ Gastrointestinal _____

☐ Eyes _____ ☐ Neurological _____

☐ Ears, Nose, & Throat _____ ☐ Allergic/Immunologic _____

☐ Dermatologic _____ ☐ Genitourinary _____

☐ Hematologic/Lymph _____ ☐ General Well-being_____

☐ Other _____ ☐ Other _____

Do you have Diabetes? ☐ Yes ☐ No If yes, do you take insulin? ☐ Yes ☐ No

If yes, number of years? _____

Do you have any artificial joints? ☐ Yes ☐ No If yes, where? ☐ Hip ☐ Knee ☐ Other:_____

Do you have a Heart Valve Implant? ☐ Yes ☐ No

Do you have a Pacemaker? ☐ Yes ☐ No

Height: _____ **Weight**: _____ **Shoe size**: _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No **Packs per day**: _____ **Previously smoked**? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No ☐ Light usage (1-2 per week) ☐ Moderate usage (1-2 per day) ☐ Heavy usage (> 2 per day)

Occupation: _____

Hobbies: _____

Exercise: _____

FAMILY HISTORY

Check any condition that an immediate family member has or has had and list the relationship to the patient.

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
☐ Alcoholism		☐ Flat Feet	
☐ Arthritis		☐ Hammertoes	
☐ Asthma		☐ Heart Disease	
☐ Bleeding Disorder		☐ High Cholesterol	
☐ Breast Cancer		☐ Hypertension	
☐ Bunions		☐ Kidney Disease	
☐ Cancer		☐ Neurological Disorder	
☐ Circulation (Feet)		☐ Smoking	
☐ Circulation (Legs)		☐ Stroke	
☐ Diabetes		☐ Other:	