UW Medicine
NORTHWEST HOSPITAL & MEDICAL CENTER
AMBULATORY NETWORK

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# Health History Form – Foot & Ankle Clinic

**DATE:** _____

**NAME: Last** _____ **First** _____ **MI**_____**Gender: ☐ M ☐ F Birthdate:** _____

**PREFERRED PHARMACY:** _____

**REASON FOR TODAY'S VISIT**: _____

| **Allergies:** | **Medication or Substance** | **Reaction** |
|---|---|---|
| ☐ No Allergies | | |
| | | |
| | | |

| **Current Medicine:** | **Label – Name** | **Dose** | **Frequency** |
|---|---|---|---|
| OR | | | |
| ☐ See attached list | | | |
| | | | |
| | | | |
| | | | |

## Social History

☐ Single ☐ Married (their name: _____) ☐ Partner (their name: _____) ☐ Other # Kids _____

Do you use tobacco products? ☐ Daily ☐ Some Days ☐ Quit ☐ Passive (around cigarette smoke) ☐ Never
Packs per Day _____ Years Smoked _____ Date Quit _____
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit Date Quit _____
Drinks per Day _____ Drinks per Week _____ Type: ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week _____ ☐ No ☐ Quit Date Quit _____
Have you ever used injected/IV drugs: ☐ Yes ☐ No
Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin
☐ Depressants ☐Hallucinogens (LSD, mushrooms) ☐ Opioids (vicodin, oxycodone)

Are you sexually active? ☐ Yes ☐ No Partners: ☐ Male ☐ Female ☐ Both Birth Control: _____

Are you working? ☐ Yes What do you do? _____ ☐ No ☐ Retired ☐ Disabled

## Medical History — Please check box for those conditions you have now or have ever had

- ☐ No Past Medical History
- ☐ Allergic Rhinitis
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Ankle Pain/Injury
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Injury
- ☐ Bleeding/Clotting Disorder
- ☐ Blood Transfusion
- ☐ Bursitis
- ☐ Cancer
- ☐ Concussion
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Atherosclerosis
- ☐ Depression
- ☐ Diabetes
- ☐ Disk Problem – Cervical
- ☐ Disk Problem – Lumbosacral
- ☐ Disk Problem – Thoracic
- ☐ Elbow Injury
- ☐ Finger Injury
- ☐ Fracture
- ☐ Foot Pain/Injury
- ☐ Gastric Ulcer
- ☐ GERD
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hip Injury
- ☐ HIV
- ☐ Hypertension
- ☐ Insomnia
- ☐ Joint Dislocation
- ☐ Joint Pain
- ☐ Knee Injury
- ☐ Kidney Disease
- ☐ Ligament Injury
- ☐ Lipid/Cholesterol
- ☐ Lung Disease
- ☐ Myocardial Infarction
- ☐ Musculoskeletal
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Patellar Subluxation
- ☐ PPD
- ☐ Seizures
- ☐ Shoulder Problem
- ☐ Sprain/Strain
- ☐ Stress Fracture
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Tendon Injury
- ☐ Thyroid Disease
- ☐ Tuberculosis

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## Surgical History — Please check box for any surgery you have had, indicate the year

☐ No Past Surgical History
☐ Amputation (_____)
☐ Ankle Surgery (_____)
☐ Appendectomy (_____)
☐ Arm Surgery (_____)
☐ Back Surgery (_____)
☐ CABG (_____)
☐ Carpal Tunnel Release (_____)
☐ Elbow Surgery (_____)
☐ Foot Surgery (_____)
☐ Gall Bladder Surgery (_____)
☐ Hand Surgery (_____)
☐ Hernia Repair (_____)
☐ Hip Surgery (_____)
☐ Joint Replacement (_____)
☐ Knee Surgery (_____)
☐ Mastectomy (_____)
☐ Neck Surgery (_____)
☐ ORIF Fracture (_____)
☐ Shoulder Surgery (_____)
☐ Spine Surgery (_____)
☐ Tonsillectomy
☐ Wrist Surgery (_____)

☐ Other:_____
_____

## Family History–Check all that apply

| Relationship | First Name | Status (circle) | No Known Problems | Anesthesia Problems | Arthritis | Asthma | Broken Bones | Cancer | Clotting Disorder | Collagen Disease | Depression | Diabetes | Dislocations | Gout | Heart Attack | Heart Disease | Hypertension | Kidney Disorder | Lipids/Cholesterol | Osteoporosis | Rheumatoid Arthritis | Scoliosis | Severe Sprains | Stroke | Sudden Death | Thyroid Disease | Tuberculosis |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | alive deceased | | | | | | | | | | | | | | | | | | | | | | | | | |
| Father | | alive deceased | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sister | | alive deceased | | | | | | | | | | | | | | | | | | | | | | | | | |
| Brother | | alive deceased | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maternal Grandmother | | alive deceased | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maternal Grandfather | | alive deceased | | | | | | | | | | | | | | | | | | | | | | | | | |
| Paternal Grandmother | | alive deceased | | | | | | | | | | | | | | | | | | | | | | | | | |
| Paternal Grandfather | | alive deceased | | | | | | | | | | | | | | | | | | | | | | | | | |

## Screening

In the past two weeks, how often have you been bothered by the following? (Please circle one response per statement.)

| | | | | |
|---|---|---|---|---|
| Little interest or pleasure in doing things | Not at all | Several days | More than half the days | Nearly every day |
| Feeling down, depressed, or hopeless | Not at all | Several days | More than half the days | Nearly every day |

Have you fallen in the past year? ☐ Yes ☐ No
Are you afraid of falling? ☐ Yes ☐ No
Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No

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## Review of Systems (current symptoms) – please check only if these are bothering you at this time

**Gastrointestinal** ☐NONE
☐ Poor Appetite ☐ Nausea ☐ Vomiting ☐ Heartburn/Indigestion ☐ Rectal Bleeding
☐ Stomach Pain ☐ Constipation ☐ Vomiting Blood ☐ Black Tarry Stools ☐ Other: _____
☐ Diarrhea ☐ Abdominal Swelling ☐ Trouble Swallowing ☐ Other: _____ ☐ Other: _____

**Constitutional** ☐NONE ☐ Fevers ☐ Weight Gain ☐ Fatigue ☐ Weight Loss

**Head / Eyes** ☐NONE ☐ Cataracts ☐ Poor Vision ☐ Dry Eyes ☐ Color Blindness

**Ears/Nose/Mouth/Throat** ☐NONE
☐ Hearing Loss ☐ Heavy Snoring ☐ Chronic Sinus Congestion ☐ Bad Teeth

**Respiratory (lungs)** ☐NONE
☐ Cough ☐ Shortness of Breath ☐ Asthma ☐ Emphysema (COPD)

**Heart** ☐NONE ☐Chest Pain ☐Palpitations ☐ Irregular Heart Beat ☐High Blood Pressure

**Genitourinary** ☐NONE ☐ Sexual Problems ☐ Blood in Urine ☐ Burning with Urination ☐ Leakage of Urine ☐ Urgency of Urination ☐ Frequency of Urination ☐ Urinary Tract Infection

**Muscles/Bones** ☐NONE ☐ Chronic Pain ☐ Muscle Weakness ☐ Arthritis ☐ Muscle Cramping ☐ Bone Pain ☐ Joint Pain

**Skin** ☐NONE ☐ Rash ☐ Itching ☐ Jaundice ☐ Psoriasis

**Neurological** ☐NONE ☐ Headaches ☐ Confusion ☐ Seizures (Epilepsy) ☐ Tremor (shaking)

**Vascular** ☐NONE ☐ Blood Clots ☐ Varicose Veins

**Psychosocial** ☐NONE
☐ Anxiety / Nerves ☐ Depression ☐ Abusive Relationship ☐ Feeling Worthless ☐ Sexual Problems ☐ Want to Hurt Yourself ☐ Sleep Problems ☐ Want to Hurt Others ☐ Alcohol Use ☐ Drug Use

**Endocrine** ☐NONE ☐ Hot Flashes ☐ High Thirst ☐ Bothered by Heat ☐ Bothered by Cold

**Blood / Lymph** ☐NONE ☐ Swollen Lymph Nodes ☐ Easy Bruising ☐ Easy Bleeding