Grand River Health
Podiatric Patient History Form

Dr. Jill Peotter

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Last Name: _____ **First Name:** _____ **MI:** _____

Today's Date: _____ **Doctor that referred you** _____

Date of Birth: _____ **Local Pharmacy:** _____

Chief Complaint

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

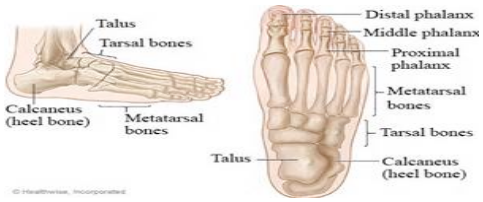
Is this injury work related? Y N

Height: _____ **Weight:** _____ **B/P** _____

History of Present Illness

Please answer the following questions

Location of the problem



_____

_____

On a scale of 1-10 with 10 being the most severe, circle the Number that best describes the problem.

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other: _____

Does anything help or make the problem worse?

Moving around Sitting down Removing shoes

Other: _____

How long does the problem last?

30 minutes 1 hour It is always there

Is anything else occurring at the same time?

Yes No If yes, please explain

Nausea Rash Headaches

Other: _____

Is the problem constant or variable?

Dull then sharp Very sharp then leaves Always there

Other: _____

Does the problem interfere with your normal functions?

Yes No Other: _____

Past Medical and Social History

List all serious illnesses in your immediate family. (Example: Diabetes, Tuberculosis, Breast Cancer, Heart Disease, etc.)

_____ _____ _____

_____ _____ _____

List any personal past illness and/or surgeries

_____

_____

_____

Allergies and reaction:

_____

_____

List any Medications you are taking now and the dosage

_____

_____

_____

Do you Smoke? Y N **Do you Drink?** Y N **Socially**

Do you now or have you had any problems related to the following systems? Circle YES or NO. Please explain any YES answers in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Feeling Poorly/Tired	Y	N
Recent Weight Loss/Gain lbs_____		

Eyes

Eye Pain	Y	N
Eyesight Problems	Y	N
Dry Eyes	Y	N
Red Eyes	Y	N
Eye Discharge	Y	N
Itchy Eyes	Y	N

Ear/Nose/Throat

Ear Pain	Y	N
Hearing Loss	Y	N
Nosebleeds	Y	N
Nasal Discharge	Y	N
Sore Throat	Y	N
Hoarseness	Y	N

Cardiovascular

Slow Heart Rate	Y	N
Fast Heart Rate	Y	N
Chest Pain	Y	N
Palpitations	Y	N
Leg Claudication	Y	N
Lower Extremity Edema	Y	N

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
PND	Y	N
Orthopnea	Y	N

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Constipation	Y	N
Diarrhea	Y	N
Melena	Y	N

Genitourinary

Dysuria	Y	N
Incontinence	Y	N
Dysmenorrhea	Y	N
Pelvic Pain	Y	N
Vaginal Discharge	Y	N
Abn Vaginal Bleeding	Y	N

Musculoskeletal

Joint Pain	Y	N
Joint Swelling	Y	N
Joint Stiffness	Y	N
Arthralgias	Y	N
Limb Pain	Y	N
Limb Swelling	Y	N

Integumentary

Skin Lesions	Y	N
Skin Wounds	Y	N
Persistent Itch	Y	N
Change in Mole	Y	N
Breast Pain	Y	N
Breast Lump	Y	N

Psychiatric

Depression	Y	N
Anxiety	Y	N
Suicidal	Y	N
Change in Personality	Y	N
Emotional Problems	Y	N

Neurological

Fainting	Y	N
Dizziness	Y	N
Confusion	Y	N
Limb Weakness	Y	N
Difficulty Walking	Y	N
Convulsions	Y	N

Endocrine

Proptosis	Y	N
Muscle Weakness	Y	N
Hot Flashes	Y	N
Deepening of Voice	Y	N
Feelings of Weakness	Y	N

Hematologic/Lymphatic

Swollen Glands	Y	N
Swollen Glands in Neck	Y	N
Easy Bleeding	Y	N
Easy Bruising	Y	N

Other

_____

_____

_____

_____

_____

Physician Use Only: (Comments/Notes)