Foot Care Associates of Texas
Dr Michael Wynn
23972 A Hwy 59 North Kingwood, TX 77339

HISTORY AND PHYSICAL EXAM

NAME ____________________ DATE ____________________

PLEASE MARK IN BLACK OR BLUE INK ONLY

HISTORY (PLEASE MARK IN EACH SECTION AND BE SPECIFIC)

REASON FOR THIS VISIT? (INCLUDE LOCATION OF PROBLEM) ____________________

HISTORY OF FOOT OR ANKLE PROBLEM ____________________

STARTED ____________________ HOW LONG ____________________

CHANGES ____________________

PRIOR TREATMENT ____________________

PRIMARY CARE DOCTOR ____________________ DATE LAST SEEN ____________________

PAST MEDICAL HISTORY

◯ DIABETES LAST HA1C RESULTS __________ (IF UNKNOWN PLEASE CALL TREATING PHYSICIAN FOR RESULTS OF LAST TEST)

◯ BLEEDING DISORDER ◯ HEART PACE MAKER ◯ LOW BLOOD PRESSURE ◯ RHEUMATIC FEVER ◯ SKIN PROBLEMS ◯ SWELLING EXTREMITIES ◯ WEIGHT LOSS

◯ ANEMIA ◯ CANCER ◯ HEPATITIS ◯ MITRAL VALVE PROLAPSED ◯ SEIZURE DISORDER ◯ STOMACH PROBLEMS ◯ THYROID PROBLEMS

◯ ASTHMA ◯ HEART DISEASE/PROBLEMS ◯ HIGH BLOOD PRESSURE ◯ NERVOUS CONDITIONS ◯ SICKLE CELL ANEMIA ◯ STROKE ◯ WEIGHT GAIN

◯ I HAVE NO MEDICAL PROBLEMS THAT I AM AWARE OF ◯ OTHER ____________________

PAST SURGICAL HISTORY (PLEASE LIST ANY AND ALL EVEN IF IT DOES NOT APPLY TO YOUR FEET)

HOSPITALIZATIONS/SURGERIES (PLEASE INCLUDE DATES): ____________________

____

____

◯ I HAVE *NEVER* HAD SURGERY OR BEEN HOSPITALIZED

ALLERGIES

◯ ANTI-INFLAMMATORY ◯ ASPIRIN ◯ CLOTHING ◯ CODEINE ◯ FOOD ◯ IODINE ◯ LOCAL ANESTHETICS ◯ PENICILLIN ◯ SULFA DRUGS ◯ SULFITES ◯ TAPE

◯ I HAVE NO ALLERGY PROBLEMS THAT I AM AWARE OF ◯ OTHER ____________________

HAVE YOU HAD ANY OF THE FOLLOWING VACCINATIONS

◯ PNEUMONIA VACCINE DATES: __________ YEAR: __________

◯ FLU VACCINE DATES: __________ YEAR: __________

FAMILY HISTORY (PLEASE INDICATE MOTHER OR FATHER BELOW)

◯ ASTHMA ◯ ARTHRITIS ◯ BLEEDING DISORDERS ◯ CANCER ◯ CIRCULATORY ◯ DIABETES ◯ GOUT ◯ HEART DISEASE ◯ HYPERTENSION ◯ PROBLEMS WITH ANESTHESIA

SOCIAL HISTORY

OCCUPATION ____________________ REQUIRE STANDING? ◯ YES ◯ NO #HOURS PER DAY __________ STUDENT ◯ YES ◯ NO

TOBACCO?(PKG/DAY) ________ ◯ CURRENT SMOKER ◯ DESIRES QUITTING ◯ FORMER SMOKER ◯ NONSMOKER ◯ SECOND HAND SMOKE EXPO

◯ DOES NOT DESIRE QUITTING ◯ SMOKELESS TOBACCO USER ◯ SMOKING HISTORY (DESCRIBE) __________ START DATE: __________

ALCOHOL? ◯ NEVER ◯ RARELY ◯ SOCIALLY ◯ FORMER DRINKER ◯ OCCASIONAL ◯ ALCOHOLIC ◯ OTHER ____________________

TEA/COFFEE/COKES/# PER DAY ____________________

PLEASE TELL US ANY AND ALL ADDITIONAL INFORMATION YOU FEEL WE SHOULD KNOW ____________________

PHARMACY NAME ____________________ PHONE NUMBER ____________________

PATIENT NAME (PRINT) ____________________ SIGNATURE ____________________

PARENT OR AUTHORIZED REPRESENTATIVE (PRINT, IF APPLICABLE) ____________________ DATE ____________________