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)

CHIEF COMPLAINT (WITH LOCATION) _____

HISTORY OF FOOT OR ANKLE PROBLEM _____

STARTED _____ HOW LONG _____

CHANGES _____

PRIOR TREATMENT _____

PRIMARY CARE DOCTOR _____ DATE LAST SEEN _____

PAST MEDICAL HISTORY

◯ DIABETES ◯ 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

◯ PNEUMOCOCCAL VACCINE DATES: _____

◯ INFLUENZA VACCINE DATES: _____

FAMILY HISTORY

◯ 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) _____ ◯ NONSMOKER ◯ FORMER SMOKER ◯ SECOND HAND SMOKE EXPO ◯ CURRENT SMOKER ◯ DESIRES QUITTING

◯ DOES NOT DESIRE QUITTING ◯ SMOKELESS TOBACCO USER ◯ SMOKING HISTORY (DESCRIBE) _____

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 _____