

# 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



### How long does the problem last?

30 minutes      1 hour      It is always there

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: \_\_\_\_\_

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)**