COMPREHENSIVE
Foot & Ankle Center
OF COLLEGEVILLE

Progressive care, *with care.*

Ali Albert Anaim, DPM, PC

Medical History

Last Name First Name Middle

Date of Birth _____/_____/_____ Height _____ Weight _____ Shoe Size _____

Chief Problem / Complaint / Injury: ___ Foot ___ Ankle ___Leg ____Right ____ Left
Date of Problem / Complaint / Injury or How long have you had this problem?
_____

How did the injury occur?
_____
_____
Where did the injury occur (if applicable) ____Work ____ Home _____ Other

Previous Treatments (check all that apply): ____ Anti-Inflammatories ____Insert ____ Surgery
____Physical Therapy ____ Brace ____ Injections ____ Cast / Boot / Immobilization ____ Other
_____
_____
Previous Tests (check all that apply): ____ Bone Scan ____ CT Scan ____ MRI ____ Ultrasound
___ X-ray

Your Medical History (check all that apply):
Angina ____ Epilepsy____ Thyroid Disease ____ Heart Disease ____
Diabetes ____ Hypertension ____ Blood Clotting ____ Seizures ____
Heart Murmur ____ Stroke ____ Phlebitis ____
Anemia ____ Foot/Leg Swell ____ Ulcer/Stomach ____
Arthritis ____ Peripheral Vas Disease ____ Bronchitis/Asthma ____

FAMILY (parents, grandparents, siblings) Medical History (check all that apply):
Angina ____ Epilepsy____ Thyroid Disease ____ Heart Disease ____
Diabetes ____ Hypertension ____ Blood Clotting ____ Seizures ____
Heart Murmur ____ Stroke ____ Phlebitis ____

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Anemia ____ Foot/Leg Swell ____ Ulcer/Stomach ____
Arthritis ____ Peripheral Vas Disease ____ Bronchitis/Asthma ____

Are you currently, or have you recently experienced any of the following SYMPTOMS?

Fever ____ Chills ____ Night sweats ____ Tremor ____ Nose bleeds ____ Irregular heartbeat ____
Chest pain ____ Trouble swallowing ____ Short of breath ____ Headaches ____ Double vision ____
Ringing in ears ____ Numbness ____ Tingling ____ Dizziness ____ Fainting ____ Hoarseness ____
Wheezing ____ Weight gain ____Weight loss ____ Weakness ____ Urethral discharge ____
Painful urination ____ Blood in urine ____ Cough ____Blood in sputum ____Blood in stool ____
Blood in vomit ____ Dark black stool ____ Constipation ____ Diarrhea ____ Indigestion/reflux ____
Abdominal pain ____ Swollen legs ____ Painful joints ____ Jaundice ____ Rash ___ Hives ____ Eczema ____
Psoriasis ____ Unusual moles ____ Anxiety ____ Depression ____ Panic ___

Please explain any item checked or list symptoms not mentioned above.

_____
_____

Please list ALL medications and the doses you are currently taking, including vitamins, aspirin, etc.

_____
_____
_____
_____
_____

Are you allergic to (check all that apply): Medications ___ Adhesive Tapes ___ Metals ___ Foods ___

If so, please list all allergies: (what happens when allergic?)

_____

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_____
_____
_____

Past Surgical History

_____
_____

Do you smoke? Yes ___ No___ If yes, how many packs per day? _____ How long have you smoked? _____

Do you drink alcohol? Yes ___ No___ If yes: Mild ___ Moderate___ Severe___
Do you use drugs? Yes ___ No ___
Are you pregnant? Yes ___ No ___ Maybe ___

_____
_____ /_____ /_____ Signature of patient / parent / guardian
Month Day Year