Intermountain Budge Clinic
Department of Podiatry
Dr. Curtis C. Pedersen, DPM

MRN:

PATIENT HISTORY FORM

Today's Date _____/_____/_____ Date of Last Physical Exam _____/_____/_____ Date of Birth _____/_____/_____

Last Name ________________________________ First Name ____________________ Middle __________________________

CHIEF COMPLAINT: What is the MAIN REASON for your visit today? (Describe your problem in detail)

____

____

HISTORY of PRESENT ILLNESS (Please answer the following questions by circling or fill in "Other")

1. Location of the problem:

2. 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

3. When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other____

4. Does anything help or make the problem worse?
Yes No If yes, What?

5. Describe any pain and/or disability:

Was the problem caused by an injury? Yes No

6. Is the pain? (please circle all that apply)
Burning Dull Sharp Throbbing Aching
Other____

7. Is the problem constant or variable?
Dull then Sharp Very Sharp then leaves Always there
Other____

8. Does anything else affect the problem?
Yes No If yes, What?

REVIEW OF BODY SYSTEMS: Have you ever had, or do you currently have any of the following?

CONSTITUTIONAL:		
Fever	YES	NO
Chills	YES	NO
Weight loss	YES	NO
Weakness	YES	NO
ENDOCRINE:	YES	NO
Hot flashes	YES	NO
Weight gain	YES	NO
Fluid retention	YES	NO
Other		
CARDIOVASCULAR:		
Chest pain	YES	NO
Palpitations	YES	NO
Irregular rhythm	YES	NO
Heart murmur	YES	NO
Other	YES	NO

RESPIRATORY:		
Shortness of breath	YES	NO
Cough	YES	NO
Sputum production	YES	NO
Coughing blood	YES	NO
Other	YES	NO
MUSCULOSKELETAL:		
Back pain	YES	NO
Joint pain	YES	NO
Stiffness	YES	NO
Muscle pain	YES	NO
Club Foot	YES	NO
Bursitis	YES	NO
Fractures	YES	NO
Sprain	YES	NO
Other	YES	NO
PSYCHIATRIC	YES	NO
Disorientation	YES	NO
Unusual thoughts	YES	NO
Depression	YES	NO

GI:		
Blood in stools	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO
Nausea/Vomiting	YES	NO
Abdominal pain	YES	NO
Other	YES	NO
HEMATOLOGIC/LYMPHATIC:		
Enlarged lymph nodes	YES	NO
Anemia	YES	NO
Bleeding disorder	YES	NO
Other	YES	NO
NEUROLOGICAL:		
Extremity weakness	YES	NO
Numbness	YES	NO
Abnormal coordination	YES	NO
Gait problem	YES	NO
Other	YES	NO

INTEGUMENTARY:		
Skin rash	YES	NO
Itching	YES	NO
Skin lesions	YES	NO
Moles	YES	NO
Deformed Nails	YES	NO
Psoriasis	YES	NO
Abrasions	YES	NO
Discoloration	YES	NO
Birthmarks	YES	NO
Hives	YES	NO
Bruises	YES	NO
Ulcerations	YES	NO
Skin Cancer	YES	NO
Other	YES	NO

PAST MEDICAL HISTORY

Do you have any allergies? YES NO

If YES, please list:____

Previous Injury/Hospitalizations/Surgeries/Serious Illnesses:

☐ None (Please include Date(s) or Years ago)

____

____

____

____

____

List any medications that you are currently taking:

☐ None

____

____

____

____

____

____

____

FAMILY AND SOCIAL HISTORY

Do any of your relatives have….?			**Who?**
Cancer	YES	NO	____________________
Colon	YES	NO	____________________
Breast	YES	NO	____________________
Prostate	YES	NO	____________________
Other	YES	NO	____________________
Heart disease	YES	NO	____________________
High blood pressure	YES	NO	____________________
Diabetes	YES	NO	____________________
Stroke	YES	NO	____________________
Any inherited diseases	YES	NO	____________________

Tobacco: Y or N If yes, how much? ____________________

If you quit, how long did you smoke? ____________________

When did you quit? ____________________

Alcohol Y or N If yes, how much? ____________________

Marital status: Married/ Single/ Divorced

Children: Y or N If yes, how many? __________________

Occupation: ____