# NEW HANOVER FOOT & ANKLE CENTER

5305-L Wrightsville Avenue, Wilmington, NC 28403

**Edwin B. Martin, III, D.P.M.**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.): ☐ M ☐ F DOB:

What is the reason for your visit today?

## PERSONAL HEALTH HISTORY

**List any medical problems that other doctors have diagnosed**

| | | | | |
|---|---|---|---|---|
| ☐ Arthritis | ☐ Blood Clot | ☐ Diabetes | ☐ HIV/AIDS | ☐ Respiratory Disease |
| ☐ Asthma | ☐ Cancer | ☐ Gout | ☐ Kidney Problems | ☐ Stroke |
| ☐ Back Problems | ☐ Circulation Problems | ☐ Heart Disease | ☐ Liver Disease | ☐ Thyroid Disorder |
| ☐ Bleeding Disorder | ☐ Depression | ☐ Hepatitis | ☐ Nerve Disorder | |

Please add or explain:

**Surgeries**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Other Hospitalizations**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

| Name the Drug | Strength | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies to medications**

| Name the Drug | Reaction You Had | Name the Drug | Reaction You Had |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## HEALTH HABITS AND PERSONAL SAFETY

| Marital Status | ☐ Single | ☐ Partnered | ☐ Married | ☐ Separated | ☐ Divorced | ☐ Widowed |
|---|---|---|---|---|---|---|

| Exercise | |
|---|---|
| | ☐ Sedentary (No Exercise) |
| | ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) |
| | ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes) |
| | ☐ Regular vigorous exercise (i.e., work or recreation 4x/per week for 30 minutes) |

| Alcohol | Do you drink alcohol? | ☐ Yes ☐ No |
|---|---|---|
| | How may drinks per week? | |

| Tobacco | Do you use tobacco? | | | ☐ Yes ☐ No |
|---|---|---|---|---|
| | ☐ Cigarettes - pks./day | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day |
| **Drugs** | Do you currently use recreational or street drugs? | | | |
| | | | | |

## FAMILY HEALTH HISTORY

| | Age | Significant Health Problems |
|---|---|---|
| Father | | |
| Mother | | |
| Sibling | ☐ M ☐ F | |
| | ☐ M ☐ F | |
| Grandmother | | |
| Grandfather | | |

## REVIEW OF SYSTMES

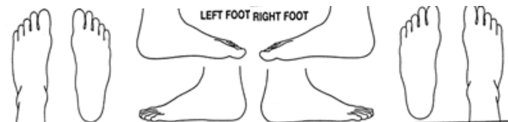
Please check if you have recently been experiencing any of the following:

| | | | | |
|---|---|---|---|---|
| **Constitutional** | ☐ Fatigue | ☐ Fever/chills | ☐ Recent weight change | ☐ No symptoms |
| **Eyes** | ☐ Blurred vision | ☐ Blindness | ☐ Floaters | ☐ No symptoms |
| **Skin** | ☐ Rash | ☐ Itching | ☐ Dry skin | ☐ No symptoms |
| **Respiratory** | ☐ Shortness of breath | ☐ Wheezing | ☐ Coughing | ☐ No symptoms |
| **Cardiovascular** | ☐ Chest pain | ☐ Swelling ankle/feet | | ☐ No symptoms |
| **Neurologic** | ☐ Seizures | ☐ Numbness | ☐ Headaches | ☐ No symptoms |
| **Gastrointestinal** | ☐ Nausea | ☐ Vomiting | ☐ Jaundice | ☐ No symptoms |
| **Genitourinary** | ☐ Frequent urination | ☐ Painful urination | | ☐ No symptoms |
| **Hematologic** | ☐ Bleeding | ☐ Excessive bruising | ☐ Use of blood thinners | ☐ No symptoms |
| **Musculoskeletal** | ☐ Pain | ☐ Weakness | ☐ Leg Cramps | ☐ No symptoms |

Please Mark the location of your foot and ankle pain:

Describe the pain/ Discomfort:

Date of injury/ problem began___/____/________




Is the problem work related?

Notes: