

Foot & Ankle Institute of Iowa

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HEALTH HISTORY

Name: _____

Date: _____

Please describe your foot and/or ankle problem: _____

When did your problem begin? _____

Have you had this problem before? _____

If yes, how long ago? _____

Regarding your feet, what symptom(s) best describes your current problem (*check all that applies*):

Swelling Pain Numbness Tingling Color Changes

Other _____

Describe any prior treatment(s) for this problem (if any): _____

If yes, by whom and when? _____

Do you have any medication allergies? Yes No

If yes, what medications and what reaction(s) did you have? (*e.g., rash, difficulty breathing, etc.*) _____

What medications (prescribed and/or over the counter) are you currently taking?

(*Please provide list, if available*) _____

Please list any surgeries or hospitalizations: _____

FAMILY HISTORY

Name: _____

Date: _____

Have you or any family member had or currently have any of the following? *(Please check all that apply) If not mark N/A*

Diabetes

You Family (Relationship): _____

High Blood Pressure

You Family (Relationship): _____

Stroke

You Family (Relationship): _____

Heart Attack

You Family (Relationship): _____

Congestive Heart Failure

You Family (Relationship): _____

High Cholesterol

You Family (Relationship): _____

Cancer (type) _____

You Family (Relationship): _____

Epilepsy

You Family (Relationship): _____

Osteoarthritis/Rheumatoid Arthritis

You Family (Relationship): _____

Gout

You Family (Relationship): _____

Poor Circulation

You Family (Relationship): _____

Hepatitis

You Family (Relationship): _____

Leg/foot/sores/ulcers

You Family (Relationship): _____

Blood Clots

You Family (Relationship): _____

Skin Trouble/Rashes

You Family (Relationship): _____