John A. Nassar, M.D., P.C.

Patient Name: Age: Today's Date:

How did you find out about Dr. Nassar/who referred you?

Why are you here today?

How long have you had this problem? Which side is involved? ☐ right ☐ left

What is your main problem?

☐ pain ☐ grinding ☐ weakness ☐ increased warmth
☐ deformity ☐ popping ☐ limp ☐ collapsing arch
☐ instability ☐ stiffness ☐ ulcer/sore ☐ numbness/tingling
☐ catching ☐ swelling ☐ redness ☐ open wound

What type of pain are you having?

☐ sharp ☐ aching ☐ throbbing ☐ burning ☐ tearing

How did it start? ☐ gradually ☐ suddenly

What could have caused this? ☐ injury ☐ accident ☐ activity ☐ unknown

Have you had the same or similar problem in the past? ☐ no ☐ yes

How severe is the pain/problem? ☐ mild ☐ moderate ☐ severe

The pain/problem is:

☐ present during activity ☐ present at rest ☐ present at night
☐ worse when starting up after rest

The pain/problem is: ☐ constant ☐ intermittent

The pain/problem is:

☐ not changing ☐ gradually getting worse ☐ rapidly getting worse
☐ gradually getting better ☐ rapidly getting better

What makes your pain/problem worse?

☐ standing ☐ walking ☐ running ☐ jumping ☐ stairs
☐ uneven ground ☐ hard surfaces ☐ dress shoes ☐ any shoes ☐ barefoot

What makes your problem better?

☐ rest ☐ elevation ☐ ice ☐ heat ☐ stretching
☐ removing shoe ☐ rubbing foot ☐ comfortable shoes ☐ avoiding aggravating activities

What types of treatments have you had?	Does this help?		
☐ anti-inflammatory medication	☐ no	☐ a little	☐ a lot
☐ pain medication	☐ no	☐ a little	☐ a lot
☐ compressive wrap	☐ no	☐ a little	☐ a lot
☐ brace	☐ no	☐ a little	☐ a lot
☐ physical therapy	☐ no	☐ a little	☐ a lot
☐ cortisone shot	☐ no	☐ a little	☐ a lot
☐ shoe insert	☐ no	☐ a little	☐ a lot
☐ custom orthotics	☐ no	☐ a little	☐ a lot
☐ cast	☐ no	☐ a little	☐ a lot
☐ cane/crutches/walker	☐ no	☐ a little	☐ a lot

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Patient Name:	Today's Date:

Who is your Primary Care Physician?	☐ none
Date last seen?	

Height:	Weight:

List all your **MEDICAL** problems:	currently being treated?
1.	☐ yes ☐ no
2.	☐ yes ☐ no
3.	☐ yes ☐ no
4.	☐ yes ☐ no
5.	☐ yes ☐ no

List all your past **SURGERIES**:	Year	Complications?
1.		☐ yes ☐ no
2.		☐ yes ☐ no
3.		☐ yes ☐ no
4.		☐ yes ☐ no
5.		☐ yes ☐ no

List all your current **MEDICATIONS**:	dose/frequency?	how long taking?
1.		
2.		
3.		
4.		
5.		

List all your past **ALLERGIES** to medications:	reaction
1.	
2.	
3.	

Have you experienced **ANY PROBLEMS** with the following?

General health	☐ current	☐ previously	Circulation	☐ current	☐ previously
Eyes	☐ current	☐ previously	Stroke	☐ current	☐ previously
Ear, Nose, Throat	☐ current	☐ previously	Seizures	☐ current	☐ previously
Heart Attack	☐ current	☐ previously	Diabetes	☐ current	☐ previously
Irregular heart beat	☐ current	☐ previously	Thyroid	☐ current	☐ previously
High blood pressure	☐ current	☐ previously	Infection	☐ current	☐ previously
Lungs	☐ current	☐ previously	Cancer	☐ current	☐ previously
Pneumonia	☐ current	☐ previously	Anemia	☐ current	☐ previously
Shortness of breath	☐ current	☐ previously	Blood Clots	☐ current	☐ previously
Stomach Ulcers	☐ current	☐ previously	Easy bleeding	☐ current	☐ previously
Acid Reflux	☐ current	☐ previously	Hepatitis	☐ current	☐ previously
Osteoarthritis	☐ current	☐ previously	HIV	☐ current	☐ previously
Rheumatoid Arthritis	☐ current	☐ previously	Drug abuse	☐ current	☐ previously
Gout	☐ current	☐ previously	Alcohol abuse	☐ current	☐ previously
Emotional problems	☐ current	☐ previously	Liver	☐ current	☐ previously
Pyschiatric disorders	☐ current	☐ previously	Kidneys	☐ current	☐ previously
Artificial bone/joints	☐ current	☐ previously	Urinary Tract	☐ current	☐ previously
Bone Infection	☐ current	☐ previously	Bowels	☐ current	☐ previously

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Patient Name:	Today's Date:

Surgical Risk Factors:

Have you experienced any of the following?			Please Explain any yes answers:
Blood clot in your legs or lungs	☐no	☐yes	
Problems with excessive bleeding	☐no	☐yes	
Latex allergy	☐no	☐yes	
Sleep Apnea	☐no	☐yes	Do you use a CPAP? ☐no ☐yes
Problems with anesthesia	☐no	☐yes	
MRSA Infection	☐no	☐yes	

Women only:

Are you pregnant?	☐no	☐yes
Have you reached menopause?	☐no	☐yes

FamilyHistory:

Family History of: ☐ Anesthesia Problems ☐ Abnormal Blood Clots ☐ Abnormal Bleeding

	Major Medical Problems	Age of Death	Cause of Death
Father			
Mother			
Siblings			
Children			

Social History:

Occupation:					
Work Status:	☐full time	☐part time	☐disabled		
Marital Status:	☐single	☐married	☐divorced	☐separated	☐widowed
Do you have children?	☐no	☐yes	How many?		
Do you live alone?	☐no	☐yes			

Do you exercise? no yes

How often? daily weekly rarely never

What type of exercise?

Do you smoke? ☐no ☐yes

How many packs per day?			For how many years?	
Previously smoked	packs per day, for		years.	
Quit smoking?	☐this year	☐1 year ago	☐5 years ago	☐>10 years ago

Do you drink alcoholic beverages?	☐no	☐yes		
How often?	☐daily	☐weekly	☐monthly	☐rarely
How many drinks?	☐1	☐1-3	☐3-6	☐>6

Do you have a history of any alcohol, substance, or drug abuse?

☐no ☐yes ☐current ☐previous

My signature below indicates that I have provided an accurate and complete medical history:

Signature _____ **Date**_____

Printed Name _____

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