Date _____

Dr. William Grant FOOT & ANKLE

PATIENT REVIEW OF SYMPTOMS FORM

Patient Name _____

Do you now, or have you had any problems related to the following symptoms?

Please circle all that apply to you.

Cardiovascular:

Chest Pain Varicose Veins High Blood Pressure Heart Murmur
Irregular Heartbeat Swelling of Legs Use of Oxygen None

Constitutional Symptoms:

Fever Chills Weakness Poor Appetite Weight Loss/Gain None

Endocrine:

Diabetes Excessive/Increased Thirst Heat/Cold Too Hot/Cold Tired/Sluggish None

Hematologic/Lymphatic:

Swollen Glands Enlarged Lymph Nodes Blood Clotting Problems
Easy Bruising or Bleeding Frequent Bleeding from Gums Anemia None

Musculoskeletal:

Joint Pain Neck Pain Sore Muscles Osteoporosis None

Skin:

Skin/Rash Lump/Growth on Skin Boils Persistent Itch Change in Skin Color None

List of Medications:_____

_____

_____

_____

List of Allergies:_____

_____

Medical History:_____

_____

Surgical History: _____

Family Medical History: _____

Do you smoke? No Yes (If Yes, Light or Heavy)

Alcohol Use? _____ How Much? _____

What is your current foot problem? _____

_____

Are you under a physician's care for the foot problem? _____

Are you pregnant? _____ If so,how many weeks/months? _____

Under whose care? _____