



DR. CHRISTOPHER A. TOTH

FOOT & ANKLE SURGICAL ASSOCIATES, LLC

### PATIENT HISTORY

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Describe your main problem: \_\_\_\_\_

Where is the problem located: \_\_\_\_\_

How did it start: \_\_\_\_\_

How long have you had this problem: \_\_\_\_\_

Previous Treatment: \_\_\_\_\_

### PAST MEDICAL HISTORY

*Have you ever had any of the following?*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Arthritis         |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Gout                | <input type="checkbox"/> Heart Attack      |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Convulsions          | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Kidney Problems   |
| <input type="checkbox"/> Liver Problems       | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Blood Clots       |
| <input type="checkbox"/> Stomach Problems     | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Fainting          |
| <input type="checkbox"/> Other: _____         |  |  |

### SURGICAL HISTORY

*Please list previous surgeries.*

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### MEDICATIONS

*Please list your medications.*

_____	_____
_____	_____
_____	_____

### ALLERGIES

*Please list any allergies to medications or other sources.*

None Allergies

\_\_\_\_\_

### FAMILY MEDICAL HISTORY

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

### SOCIAL HISTORY

Tobacco Use:       Never       Previously but quit       Current packs per day \_\_\_\_\_

Alcohol Use:       Never       Social       Moderate       Daily

Are you pregnant:       No       Yes      Month Due: \_\_\_\_\_

*I understand that honest and complete answers to each question on both pages are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or member of the office staff for assistance.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_