FOOT AND ANKLE CENTER OF WEST TEXAS
BRIAN K. MIDDLEBROOK, DPM

Patient Name: _____ DOB: _____

Review of Systems:

As you review the list, please circle any of the problems which have significantly affected you.

Constitutional	**Musculoskeletal**	**Integumentary**
Recent weight gain/amt___	Joint pain	Rash
Recent weight loss/amt___	Joint swelling/redness	Calluses/Corns/ Lesions
Fever	Stiffness	Discolorations in skin /Nails
Nausea/Vomiting	Lower extremity pain	
	Burning/ Tingling/ Strange Sensations	
	Cramping of feet or legs	

Current Weight;_____
Height:_____ Primary Physician: _____

MEDICAL HISTORY

Please circle any of the following that you ever had:

Cancer	Heart Problems	High Blood Pressure	Stroke
Anemia	Kidney Disease	Thyroid Disorders	Gout
Back Problems	Arthritis	Rheumatoid Arthritis	Fibromyalgia

Autoimmune Disorder: _____ Other: _____

Are you diabetic? No/ Yes How long: _____ Name of treating physician: _____

Are you on dialysis? No/ Yes How Long: ____ Name of treating physician: _____

Previous Surgeries:

Previous Foot History: Have you had:

Fractures? No/ Yes Where:_____

Gout? No/ Yes Treatment: _____

Fungus? No/ Yes Treatment: _____

Diabetic Foot Wounds? No/ Yes

What size shoes do you wear? _____

Family History: Any blood relative (limited to parents, grandparents, siblings, children) have:

Foot problems Diabetes Heart Disease High Blood Pressure

Social History

Do you drink alcohol? No/ Yes How many times a week? _____

Do you drink caffeine? No/ Yes How many cups per day? _____

Do you use tobacco products including vaping? No/ Yes/ Quit How many years? _____

Do you use recreational drugs for non medical purposes? No/ Yes

Do you exercise regularly? No/ Yes What type: _____

Do you sleep well at night? Yes/ No Why not: _____

MEDICATIONS:

Name of medication	Name of Medication

Allergies: Please list any medications you are allergic to:

Preferred Pharmacy: _____

_____