Beaumont Foot Specialist

Patient Name: _____ Date of Birth: _____ Date: _____

PODIATRIC HISTORY

Chief Complaint Location: ☐ Left ☐ Right ☐ Both

Description of Primary Problem/Pair _____

_____

_____

How long has it been bothering yc 1 2 3 4 5 6 7 8 9 10 _____ days weeks months

Onset: ☐ Slow ☐ Sudden ☐ Traumatic ☐ Date Of Injury _____

Symptoms Are Worse: ☐ Morning ☐ Afternoon ☐ Bedtime ☐ All Day ☐ With Activity ☐ W

List Previous Treatment: _____

_____

Describe Type of Pain: ☐ Dull ☐ Aching ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Burnin
☐ Tingling ☐ Cramping ☐ Numbness ☐ Other _____

Who is Your Primary Care Physicia _____ Date last seen _____ Did they refer you h

Did you have a Previous Podiatrist Yes No If yes, Who? _____ When? _____

Additional Foot/Ankle Concern: _____

MEDICAL HISTORY

☐ AIDS/HIV	☐ Chemical Dependency	☐ Heart Murmur	☐ Psoriasis
☐ Anemia	☐ Chest Pain	☐ Hemophilia	☐ Rheumat
☐ Anxiety	☐ Depression	☐ Hepatitis	☐ Schizoph
☐ Arthritis/type _____	☐ Diabetes	☐ High Blood Pressure	☐ Seizures/
☐ Artificial Heart Valve	Type _____ How long _____	☐ High Cholesterol	☐ Stroke
☐ Artificial Joint	☐ Emphysema	☐ Intestinal Disorder	☐ Thyroid p
☐ Asthma	☐ Eye Problems	☐ Kidney Disorder	Type __
☐ Back Problems	☐ Fibromyalgia	☐ Liver Disease	☐ Tubercul
☐ Bleeding Disorder	☐ Gastric Reflux	☐ Low Blood Pressure	☐ Ulcers (s
☐ Bipolar Disorder	☐ Gout	☐ Neuropathy	☐ Varicose
☐ Blood Clot/DVT	☐ Heart Attack	☐ Pacemaker	☐ Other
☐ Cancer/ _____	☐ Heart Failure	☐ Paralysis	☐ Pain Man

Additional History: _____

WOMEN, are you Pregnant? Yes No Breastfeeding? Yes No

SURGICAL AND HOSPITALIZATION HISTORY

☐ Appendectomy	☐ Bypass Surgery	
☐ Tonsillectomy	☐ Foot Surgery	L _____ R _____
☐ Hysterectomy		L _____ R _____
☐ Hernia Surgery	☐ Other :	
☐ Gall Bladder	_____	

_____

_____

REVIEW OF SYSTEMS (circle any problems you are CURRENTLY having)

CONSTITUTIONAL..... fever, chills, weight loss, fatigue

SKIN..... rash, excessive sweating, color change, itching, sores, nails, callus / corn

HEENT..... sinus problems, allergies, visual or hearing problems, nosebleeds, sleep apnea

ENDOCRINE..... excessive thirst, heat or cold intolerance, weight loss or gain, hormonal changes

CHEST/RESPIRATORY.... shortness of breath, wheezing, cough

CARDIOVASCULAR..... chest pain/angina, irregular heartbeat, swelling of legs/feet, heart trouble

ABDOMINAL..... peptic ulcer, irritable bowel syndrome, stomach pain, gallbladder problems, heartburn, diarr

MUSCULOSKELETAL..... joint pain, stiffness, neck or low back pain,muscle pain, shoulder or knee problems, hip prob

NEUROLOGICAL..... fainting spells, blackouts, burning pain, sciatica, numbness, weakness, gait problem
dizziness, tremors, cramping in foot and/or leg, memory problems, seizures

FAMILY HISTORY

(*Family history includes mother,father,grandparents or siblings of patient) Please list **WHO** in the space

☐ Heart Disease _____ ☐ Gout _____

☐ Diabetes _____ ☐ Arthritis _____

☐ High Blood Pressure _____ ☐ Neuropathy _____

☐ Stroke _____ ☐ Bleeding Disorder _____

☐ Varicose Veins _____ ☐ Foot Problems _____

Father: Living at age _____ Deceased at age _____ Cause of death _____

Mother: Living at age _____ Deceased at age _____ Cause of death _____

SOCIAL HISTORY

Do you smoke? Y N Packs/day? _____ # of yrs? _____ Please List Your Occupat

Previously smoke? Y N Packs/day? _____ # of yrs? _____ _____

Drink Alcohol? Y N #of drinks _____ daily socially occasionally excessively

CURRENT MEDICATIONS

Name: _____ Dosage / Frequency: _____

Name: _____ Dosage / Frequency: _____

Name: _____ Dosage / Frequency: _____

Name: _____ Dosage / Frequency: _____

Name: _____ Dosage / Frequency: _____

Name: _____ Dosage / Frequency: _____

Name: _____ Dosage / Frequency: _____

Name: _____ Dosage / Frequency: _____

Name: _____ Dosage / Frequency: _____

Name: _____ Dosage / Frequency: _____

ALLERGIES

Local anesthesia	Y	N	General anesthesia	Y	N	Tape/adhesive	Y
Aspirin	Y	N	Latex	Y	N	Betadine	Y
Penicillin	Y	N	IVP Dye	Y	N	Iodine	Y
Levaquin	Y	N	Sulfa	Y	N	Anti-inflammatory	Y
Cipro	Y	N	Tetanus	Y	N	Steroids	Y

Codeine **Y** **N** Other Medications: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

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/Epilepsy

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