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 years

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

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

List Previous Treatment: _____

_____

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

Who is Your Primary Care Physicia _____ Date last seen _____ Did they refer you here? ___

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

Additional Foot/Ankle Concern: _____

MEDICAL HISTORY

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/type _____
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Bipolar Disorder
- ☐ Blood Clot/DVT
- ☐ Cancer/ _____
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Depression
- ☐ Diabetes
  Type _____ How long _____
- ☐ Emphysema
- ☐ Eye Problems
- ☐ Fibromyalgia
- ☐ Gastric Reflux
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Intestinal Disorder
- ☐ Kidney Disorder
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Neuropathy
- ☐ Pacemaker
- ☐ Paralysis
- ☐ Psoriasis
- ☐ Rheumatic Fever
- ☐ Schizophrenia
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Thyroid problems
  Type _____
- ☐ Tuberculosis
- ☐ Ulcers (stomach)
- ☐ Varicose Veins
- ☐ Other
- ☐ Pain Management

Additional History: _____

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

SURGICAL AND HOSPITALIZATION HISTORY

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

_____

_____

_____

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, diarrhea, constipation

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

NEUROLOGICAL..... fainting spells, blackouts, burning pain, sciatica, numbness, weakness, gait problems 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 provided

☐ 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 Occupation:

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	N
Aspirin	Y	N	Latex	Y	N	Betadine	Y	N
Penicillin	Y	N	IVP Dye	Y	N	Iodine	Y	N
Levaquin	Y	N	Sulfa	Y	N	Anti-inflammatory	Y	N
Cipro	Y	N	Tetanus	Y	N	Steroids	Y	N

Codeine Y N Other Medications: _____.

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