

## PATIENT HISTORY

**\* Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you may have.**

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

1) What is the main problem with your feet or ankles? \_\_\_\_\_  
\_\_\_\_\_

2) When did you first notice the condition? \_\_\_\_\_

3) Is this an injury? \_\_\_Yes \_\_\_No      If Yes, when did it occur? \_\_\_/\_\_\_/\_\_\_  
If Yes, did it happen at work? \_\_\_Yes \_\_\_No      Are you claiming Workman's Comp? \_\_\_Yes \_\_\_No

4) Check all of the following that apply:

**Type of Pain**    \_\_\_ Burning    \_\_\_ Tingling    \_\_\_ Sharp    \_\_\_ Dull Ache    \_\_\_ Throbbing  
                     \_\_\_ Shooting    \_\_\_ Stabbing    \_\_\_ Numbness

**When Painful**    \_\_\_ Upon Standing    \_\_\_ During Walking    \_\_\_ After Walking  
                     \_\_\_ During Sports    \_\_\_ Worse with Activity    \_\_\_ Better as Activity Continues  
                     \_\_\_ Worse when standing    \_\_\_ With Shoes    \_\_\_ Without Shoes  
                     \_\_\_ A.M    \_\_\_ P.M    \_\_\_ Lying in Bed    \_\_\_ Always

5) How painful is your condition? If **0** = "no pain" and **10** = "the worst pain you have ever experienced", please circle your pain level:    **0**    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**

6) How has this affected your daily routine and what activities does this keep you from performing? \_\_\_\_\_  
\_\_\_\_\_

7) Have you had foot care before? \_\_\_Yes \_\_\_No    By whom and when: \_\_\_\_\_  
\_\_\_\_\_

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**MEDICATIONS**

Pharmacy: \_\_\_\_\_ Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Medication	Dosage	How Often Taken?	What is it Taken for?

**ALLERGIES**

- NONE       OTHER \_\_\_\_\_  
 Penicillin     Sulfa       Iodine       Aspirin       Anesthetics       Latex  
 Codeine       Demerol     Darvocet     Cortisone     Environmental     Food

Type of Reactions: \_\_\_\_\_

**MEDICAL HISTORY**

\* Please check any of the following conditions that you have or have had in the past.

- Diabetes       Fibromyalgia     Tumors       Epilepsy       Nerve Conditions     Heart Problems  
 Arthritis       Gout             Asthma/COPD     Glaucoma       Stomach Ulcers       Skin Disorders  
 Tuberculosis     Anemia         Bursitis       Aids (HIV)     Lung Disease       Kidney Problems  
 Sickle Cell     Stroke         Hepatitis       Osteoporosis     Bleeding Problems     Colitis / Crohn's  
 Mental Disorders     Poor Circulation     High Blood Pressure     Joint Implants     Thyroid Disease  
 Rheumatic Fever     Heart Burn / Reflux     Sexually Transmitted Diseases     High Cholesterol  
 Cancer; type \_\_\_\_\_

Diabetes; What is the name, phone number, and address of the doctor treating you for diabetes? \_\_\_\_\_

When was your last visit? \_\_\_\_/\_\_\_\_/\_\_\_\_      What is your average blood sugar reading? \_\_\_\_\_

- Are you pregnant? \_\_\_\_Yes \_\_\_\_No      How many months? \_\_\_\_\_

**SURGICAL HISTORY**

Procedure	Date	Complications

7) Have you ever been hospitalized other than for surgery?  Yes  No Explain \_\_\_\_\_

8) Have you ever had an injury to the lower extremity?  Yes  No Explain \_\_\_\_\_

**FAMILY HISTORY**

\* Please check all that apply

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

**SOCIAL HISTORY**

Date of last physical Exam: \_\_\_/\_\_\_/\_\_\_ Occupation: \_\_\_\_\_

Activities: \_\_\_\_\_

Level of activity:  Occasional  Weekly  Competitive  Professional

Do you smoke tobacco?  Yes  No

If Yes: # packs per day? \_\_\_ # cigarettes per day? \_\_\_ # of years smoking? \_\_\_

If No: Did you ever smoke?  Yes  No

If Yes: How long ago did you stop smoking? \_\_\_\_\_

Do you drink alcohol?  Yes  No

If Yes: How much? \_\_\_ < 1 per week \_\_\_ 1-2 per week \_\_\_ 1-2 per day \_\_\_ more than 3 per day

Recreational drug use

\* Any type of drug use is a personal choice and will in no way adversely effect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer: \_\_\_Yes \_\_\_No

If Yes: What substance and how often used? \_\_\_\_\_

**REVIEW OF SYSTEMS**

\*If you are experiencing any of the following please circle

**Head:** chronic headaches, concussions, dizziness, loss of consciousness. **Eyes:** glasses, contacts, double vision, blurred vision, blindness, cataracts. **Ears:** decreased or loss of hearing, ringing in the ears, chronic earaches. **Nose:** drainage or infection, blockage, bleeding, sinusitis. **Throat:** chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech. **Cardiovascular:** chest pain, shortness of breath, palpitations, murmurs, heart valve disease, anemia, leg cramps. **Respiratory:** bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough. **Gastrointestinal:** nausea, vomiting, diarrhea, constipation, weight gain or loss, blood in stool, black stool, excessive gas, loss of appetite. **Genitourinary:** chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine, discharge from penis or vagina. **Gynecologic:** Irregular or painful periods, absence of period if not in menopause, vaginal discharge.

**Other:** \_\_\_\_\_

- Do your legs swell? \_\_\_Yes \_\_\_No
- Do you have back problems or have had a back injury? \_\_\_Yes \_\_\_No

I am not experiencing any of the above symptoms.

**NOTICE OF PRIVACY PRACTICES (HIPAA REGULATIONS)**

You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

**CONSENT**

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_