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: _____

_____

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 _____ Other: _____

☐ 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. **Respiratrory:** bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough. **Gastointestinal:** 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: ____/____/____**