

Patient's Name: _____ Date of Birth: _____

REASON FOR VISIT

Please describe your present foot or ankle concerns, problems or symptoms:

1. _____
2. _____

Have you ever been seen by a podiatrist? Yes No

If yes, for what reason? (Please include who and when.) _____

MEDICAL HISTORY

When was your last physical exam? _____

Family doctor's first and last names: _____ Phone #: (____) _____

1. **Are you currently under medical treatment?** Yes No

If yes, for what? _____

2. **Care Team:** List other specialists you see such as cardiologists, dermatologists, chiropractors, etc.
Type of Specialist **Name and contact info**

_____	_____
_____	_____
_____	_____

3. **Please check any of the following to which you've had allergic reactions:** **NONE**

Adhesive Tape Iodine Penicillin

Aspirin Latex Sulfa

Codeine Local Anesthetics (Novocaine)

Other (please explain): _____

4. **Are you currently taking any prescription or over-the-counter medications?** Yes No

I have brought an updated list of medications with me.

If you answered "yes" and you didn't bring an updated list, please list them:

Name of Medication/Dosage/When Taken

Reason for Medication

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. **Local pharmacy, location and phone #:** _____

Mail order pharmacy: _____

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MEDICAL HISTORY (CONTINUED)

6. Have YOU ever had the following? (Please check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Anemia (Low Blood Count) | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hypoglycemia (Low Blood Sugar) |
| <input type="checkbox"/> Arthritis Type: _____ | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Blood Clots (e.g. DVT) | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> COPD (Emphysema) | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Peripheral Arterial Disease |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 | <input type="checkbox"/> Phlebitis |
| How Long: _____ | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Hard of Hearing | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Hardening of Arteries | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Murmur (e.g. AFib, VFib) | <input type="checkbox"/> Thyroid Function <input type="checkbox"/> High <input type="checkbox"/> Low |
| <input type="checkbox"/> Hepatitis A B C D (circle one) | <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Active <input type="checkbox"/> Inactive |
| <input type="checkbox"/> Herniated Disc (What level? _____) | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Other (please explain): _____ | |

7. Have YOU ever had an operation, especially to the legs, ankles or feet? Yes No

- If yes, please describe: _____
- | | |
|---|---|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Bypass Surgery <input type="checkbox"/> Heart <input type="checkbox"/> Leg | <input type="checkbox"/> Joint Replacement (Which? _____) |
| <input type="checkbox"/> Catheterization (Heart) | <input type="checkbox"/> Orthopedic (Body area? _____) |
| <input type="checkbox"/> Foot/Ankle Surgery | <input type="checkbox"/> Pacemaker/Defibrillator (circle one) |
| <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Stents <input type="checkbox"/> Heart <input type="checkbox"/> Leg |
| <input type="checkbox"/> Gastric Bypass or Lap Band (circle one) | <input type="checkbox"/> Tonsils |

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MEDICAL HISTORY (CONTINUED)

8. Has *any member of your immediate family* been treated for the following? UNKNOWN
(Please check all that apply AND circle the appropriate family member.) NONE
F = father M = mother B = brother Si = sister So = son D = daughter
- | | | | | | | | | | | | | | |
|------------------------------------|---|---|---|----|----|---|--|---|---|---|----|----|---|
| <input type="checkbox"/> Arthritis | F | M | B | Si | So | D | <input type="checkbox"/> Heart Disease | F | M | B | Si | So | D |
| <input type="checkbox"/> Cancer | F | M | B | Si | So | D | <input type="checkbox"/> High Blood Pressure | F | M | B | Si | So | D |
| <input type="checkbox"/> Diabetes | F | M | B | Si | So | D | | | | | | | |
9. Do you smoke or use tobacco products? Currently: how much: _____ Formerly Never
10. Do you vape? Yes No
11. Do you use illegal drugs? Yes No
12. Do you use alcohol? Yes No
13. What is your marital status? Single Married Divorced Widowed
14. What is your occupation? _____ Retired
15. Do you have or are you subject to any of the following? (Please check all that apply.)
- | | |
|---|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fever/Chills |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Foot/Leg Pain at Night |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Foot/Leg Cramps When Walking |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Foot/Leg Cramps at Night |
| <input type="checkbox"/> Burning Pain/Tingling/Numbness | <input type="checkbox"/> MRSA or VRE Infection (Previous) |
| <input type="checkbox"/> Calf Pain | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Chronic Infections | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Shortness of Breath at Rest |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Shortness of Breath When Active |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Swelling of Legs |
- NONE

I CERTIFY THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____