PATIENT HISTORY

Please fill out **FRONT AND BACK portions of **ALL FORMS** to the best of your ability. The staff will go over the form and answer any questions you may have.**

Name: _____ Date: __ /__ /____

E-mail address: _____ DOB: __ /__ / ____

May we contact you via e-mail _____YES _____NO

Age: ____ Height: _____ Weight: _____ Shoe Size: _____

Were you referred to our office? YES NO If yes, by whom? _____

If you were not referred by someone, how did you find out about our office? _____
_____

1. What is the main problem with your feet and/or ankles? _____
_____
_____

2. When did you first notice this condition? _____
3. Is the condition due to an injury? ____YES ____NO If yes, when did it occur? __ / __ / ____
If yes, did the injury 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
___Shooting ___Stabbing ___Numbness

Pain ___Upon Standing ___During Walking ___After Walking
___During Sports ___A.M. ___P.M. ___Always
___While Lying in Bed
___Worse When Standing ___Worse With Activity
___Better As Activity Continues
___Worse Wearing Shoes ___Worse Without Shoes

5. How painful is your condition? 0 = NO PAIN and 10 = WORST PAIN EVER EXPERIENCED

Please circle your pain level: 0 1 2 3 4 5 6 7 8 9 10

6. How has this condition affected your daily routine and what activities does this keep you from performing? _____
_____

7. Have you had foot care before? ___YES ___NO If yes, by whom and when: _____
_____

MEDICATIONS

PHARMACY: _____ Location: _____ Phone:_____

Note: If you have a list of medications that we are able to make a copy of, you do not need to fill out this part of the form.

**MEDICATION	DOSAGE	HOW OFTEN TAKEN?	WHAT IS IT TAKEN FOR?**

****Need this information, please.**

ALLERGIES

□ NONE □ OTHER _____

□ Penicillin □ Sulfa □ Iodine □ Aspirin □ Anesthetics □ Latex

□ Codeine □ Demerol □ Darvocet □ Cortisone □ Environmental □ Food

TYPE OF REACTION: _____

MEDICAL HISTORY

Primary Care Physician (PCP): _____

Date of Last Physical Exam: __ / __ / ____

Please check any of the following **conditions** that you **currently** have:

□ Diabetes □ Thyroid Disease □ Tumors □ Cancer- _____ □ Epilepsy □ Gout

□ Arthritis □ Bursitis □ Asthma □ COPD □ Lung Disease □ Skin Disorders

□ Heart Problems □ High Blood Pressure □ High Cholesterol □ Stroke □ Glaucoma

□ Anemia □ AIDS/HIV □ Sexually Transmitted Disease □ Stomach Ulcers □ Heart Burn

□ Acid Reflux □ Colitis / Crohn's □ Nerve Conditions □ Mental Disorder □ Rheumatic Fever

□ Kidney/Urinary Problems □ Hepatitis ___ □ Sickle Cell □ Tuberculosis □ Osteoporosis

□ Joint Implants _____ □ _____

□ **DIABETES:** WHAT IS THE NAME, PHONE #, AND ADDRESS OF THE DOCTOR TREATING YOU FOR DIABETES?

_____

When was your last visit? __ / __ / ____ What is your average blood sugar reading? _____

List any **conditions** that you had in your **past**, but have resolved:_____

_____

Are you currently pregnant? ___ YES ___ NO If yes, how many months? _____

SURGICAL HISTORY

PROCEDURE	DATE	COMPLICATIONS

HAVE YOU EVER BEEN HOSPITALIZED OTHER THAN FOR SURGERY? ___ YES ___ NO
EXPLAIN: _____

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 DISEASE				
CANCER (TYPE)				
OTHER				

SOCIAL HISTORY

Occupation: _____

Activities: _____

Level of activity: ___ Occasional ___ Weekly ___Competitive ___ Professional

DO YOU SMOKE TOBACCO? ___ YES ___ NO If yes: # of packs per day ___ # cigarettes per day? ___
# of years smoking? ___

DID YOU EVER SMOKE? ___ YES ___ NO If yes: How long ago did you quit smoking? _____

DO YOU DRINK ALCOHOL? ___ YES ___NO If yes: How much? __< 1/week __1-2/week __1-2/day __more

RECREATIONAL DRUG USE

❿ Any type of drug use is a personal choice and will in no way adversely affect 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

❿ If yes: What substance and how often used? _____

REVIEW OF SYSTEMS (ROS)

If you are experiencing any of the following, please circle.

Head: chronic headaches, concussion, dizziness, loss of consciousness

Eyes: glasses, contacts, double vision, blurred vision, blindness, cataracts

Ears: decrease 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 (menstrual cycles), absence of period if not 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)

□ I have read or been 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: __ / __ / ____