Patient Acct#

☐ Only Changes To The Previous History Information Are Noted

1 PATIENT IDENTIFICATION AND CONTACT INFORMATION

First Name: MI: Last Name:

Your type of Job Activity / Occupation:

☐ I prefer to be addressed as: Mr. Mrs. Miss Ms. Dr.

Soc. Sec. No.: Sex M / F Age Birth Date: / / Shoe Size: Weight: Height:

☐ I prefer to be addressed by: O First Name O Nick Name

Phone Numbers For Contacting You:

Day: ( ) _____ - _____

Evening: ( ) _____ - _____

Cell/ Pager ( ) _____ - _____

In Case of Emergency, Please Call:

_____

Day: ( ) _____ - _____

Evening: ( ) _____ - _____

Please Provide Your Preferred Pharmacy:

_____

Street / City: _____

Day: ( ) _____ - _____

2 COMPREHENSIVE PATIENT MEDICAL HISTORY ROS/PFSH

Have you had/been treated for?

☐ Corns/ Calluses
☐ Leg or Foot Ulcers
☐ Broken foot bone(s)
☐ Hammer/Mallet toes
☐ Cramps in legs/feet
☐ Lower back pain
☐ Gait (Walking) problems
☐ Childhood foot problems
☐ Warts
☐ Fungal Nails
☐ Neuroma
☐ Broken Ankle
☐ Bunions
☐ Arch pain
☐ Knee pain
☐ In-toeing
☐ Rash
☐ Athlete's Foot
☐ Ingrown nails
☐ Foot Numbness
☐ Ankle sprain
☐ Flat feet
☐ High arch feet
☐ Heel pain
☐ Toe walking
☐ ***NONE of these***

List relationship to you of family members who have had:

Diabetes _____ Foot Problems _____
Arthritis _____ Heart Attack _____
Stroke _____ High Blood Pressure _____
Cancer _____ Birth Defects _____

# of childbirths ___ Are you currently pregnant? ☐ **Yes** ☐ **No**
Are you slow to heal after cuts? ☐ **Yes** ☐ **No**
Any abnormal bruising, bleeding or scarring? ☐ **Yes** ☐ **No**

Did you previously or do you now wear:

Shoe inserts? **Y N** Still using them? **Y N** Do or did they help? **Y N**
Orthotics? **Y N** Still using them? **Y N** Do or did they help? **Y N**
The orthotics were obtained from: O Another Podiatrist O An Orthopedist
O A Physical Therapist O A Chiropractor O Other:_____

Are your first steps out of bed painful? Y N …then subsides? Y N
Do you get leg cramps…..during the day? Y N …at night? Y N
Percent of walking hours spent on your feet? 20% 40% 60% 80% 100%
List the sports/type of dance you are active in: _____

Does the foot pain limit your desired activities? ☐ **Yes** ☐ **No**
Do you have any difficulty in walking? ☐ **Yes** ☐ **No**
Any pain in calves or buttocks when walking? ☐ **Yes** ☐ **No**
Is the pain relieved by stopping or standing still? ☐ **Yes** ☐ **No**

Do you smoke now? ☐ **No** ☐ **Yes** **Packs/day** _____ **Years** _____
Did you ever smoke? ☐ **No** ☐ **Yes** **Packs/day** _____ **Years** _____
If you quit, when did you do so? _____
Alcoholic beverages? *(Circle one)* None Rarely Moderately Daily Quit
Recreational Drugs? *(Circle one)* None Rarely Moderately Daily Quit

Are you currently taking any medications? List below! ☐ **Yes** ☐ **No**
Are you taking Insulin? If yes, list below. ☐ **Yes** ☐ **No**

When noting: A = As needed, x/ = times per, D = day(s), W = weeks(s), M = month(s), Y = year(s)

List: Medications	Dose?	How Often?	For how long?
_____	_____	**A,** _____ **x/ D W,** _____	**D W M Y**
_____	_____	**A,** _____ **x/ D W,** _____	**D W M Y**
_____	_____	**A,** _____ **x/ D W,** _____	**D W M Y**
_____	_____	**A,** _____ **x/ D W,** _____	**D W M Y**
_____	_____	**A,** _____ **x/ D W,** _____	**D W M Y**

Are you taking your medications as prescribed? ☐ **Yes** ☐ **No**

Do you have or have you ever been treated for:

☐ Stroke
☐ Phlebitis
☐ Diabetes
☐ Hepatitis
☐ Gout
☐ Sciatica
☐ Alzheimer's
☐ Epilepsy
☐ Glaucoma
☐ Asthma
☐ Cancer
☐ Other(s):_____
☐ Heart Attack
☐ Vascular Disease
☐ Poor Circulation
☐ Liver Disease
☐ Arthritis
☐ Rheumatic Fever
☐ Keloid/Thick Scar
☐ Nerve Disorder
☐ Kidney Disease
☐ Lung Disease
☐ Stomach Ulcer
☐ High Blood Pressure
☐ A Heart Condition
☐ Headaches
☐ Anemia
☐ Osteoporosis
☐ Lyme's Disease
☐ Hearing/Ear Disorder
☐ Psychiatric Disorder
☐ Thyroid Problem
☐ Tuberculosis
☐ ***NONE of these***

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

(Check the answer box that applies) If yes, what happens?

Penicillin	☐ **No**	☐ **Yes**	_____
Other antibiotics (list below)	☐ **No**	☐ **Yes**	_____
Morphine	☐ **No**	☐ **Yes**	_____
Codeine	☐ **No**	☐ **Yes**	_____
Demerol	☐ **No**	☐ **Yes**	_____
Other narcotics (list below)	☐ **No**	☐ **Yes**	_____
Novocaine	☐ **No**	☐ **Yes**	_____
Other anesthetics (list below)	☐ **No**	☐ **Yes**	_____
Aspirin	☐ **No**	☐ **Yes**	_____
Empirin, Tylenol (if yes, circle)	☐ **No**	☐ **Yes**	_____
Advil, Aleve, or Motrin (circle)	☐ **No**	☐ **Yes**	_____
Other pain remedies (list below)	☐ **No**	☐ **Yes**	_____
Sulfa drugs	☐ **No**	☐ **Yes**	_____
Adhesive tape	☐ **No**	☐ **Yes**	_____
Shrimp, Iodine, or Merthiolate	☐ **No**	☐ **Yes**	_____
Any other drugs or medications	☐ **No**	☐ **Yes**	_____

Others: _____

Do you have vascular grafts? *(If yes, explain below)* ☐ **Yes** ☐ **No**
Do you have joint implants? *(If yes, explain below)* ☐ **Yes** ☐ **No**
Do you have replacement heart valves? *(If yes, explain below)* ☐ **Yes** ☐ **No**
Are you now under active chemotherapy? *(If yes, explain below)* ☐ **Yes** ☐ **No**
Have you had any other serious illness? *(If yes, explain below)* ☐ **Yes** ☐ **No**
Have you had any surgery? *(If yes, explain below)* ☐ **Yes** ☐ **No**
Have you ever been hospitalized or been under medical care over 24 hours? *(If yes, explain below)* ☐ **Yes** ☐ **No**

Had Surgery for: on date of: w/ complications of:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Anything else that you want to tell the doctor? ☐ **Yes** ☐ **No**

Illnesses/Explanations: _____

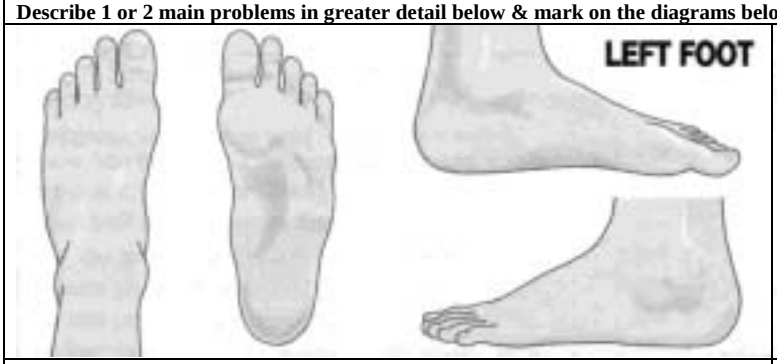
Please Continue on the Next Page to Provide Additional Details

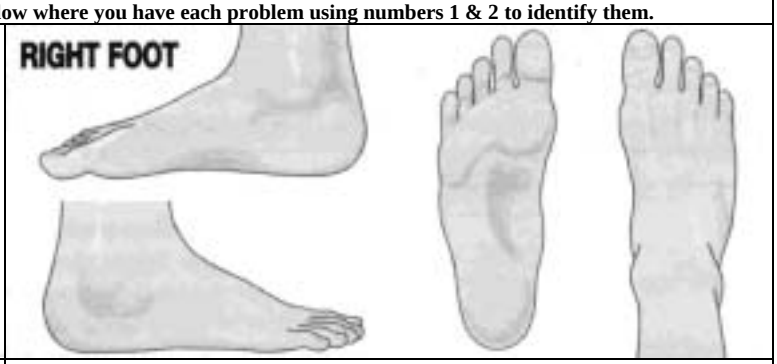
Patient CC# (s)

3 Patient's Current Chief Complaints

Patient CC# (s)

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below where you have each problem using numbers 1 & 2 to identify them.





❶ Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and its cause if you know. **Please describe associated pain to the right ➔**

My first problem is … ☐ **On Left foot** ☐ **On Right foot** ☐ **On Both feet**

It cause me difficulty: ☐ **walking,** ☐ **wearing shoes, and/or it …**

_____

_____

_____

_____

_____

_____

_____ **Is problem work related?** ☐**Y** ☐**N**

Date of injury: / / **Date of report to employer:** / /

Pain: Please indicate the severity of your pain or discomfort:

☐**None…** ☐**Mild…** ☐**Moderate…** ☐**Strong…** ☐**Severe**

My Pain/Discomfort is:

☐**Shooting Pain**
☐**Throbbing Pain**
☐**Sharp Pain**
☐**Burning Pain**
☐**Itching Pain**
☐**Aching Pain**
☐**Tenderness**
☐**Dull Pain**
☐**Tingling**
☐**Numbness**

How long ago did the problem (pain) start?:

_____ O days, O weeks, O months, O years ago

The pain from my problem occurs:

☐ while walking and/or ☐ while not walking

☐ and/or: _____

_____

Previous medical treatment(s) or home remedies:

_____

_____

_____

_____

❷ Please mark the location of your second problem or pain on the diagrams above with a number 2. Describe your problem below and its cause if you know. **Please describe associated pain to the right ➔**

My second problem is … ☐ **On Left foot** ☐ **On Right foot** ☐ **On Both feet**

It cause me difficulty: ☐ **walking,** ☐ **wearing shoes, and/or it …**

_____

_____

_____

_____

_____

_____

_____ **Is problem work related?** ☐**Y** ☐**N**

Date of injury: / / **Date of report to employer:** / /

Pain: Please indicate the severity of your pain or discomfort:

☐**None…** ☐**Mild…** ☐**Moderate…** ☐**Strong…** ☐**Severe**

My Pain/Discomfort is:

☐**Shooting Pain**
☐**Throbbing Pain**
☐**Sharp Pain**
☐**Burning Pain**
☐**Itching Pain**
☐**Aching Pain**
☐**Tenderness**
☐**Dull Pain**
☐**Tingling**
☐**Numbness**

How long ago did the problem (pain) start?:

_____ O days, O weeks, O months, O years ago

The pain from my problem occurs:

☐ while walking and/or ☐ while not walking

☐ and/or: _____

_____

Previous medical treatment(s) or home remedies:

_____

_____

_____

_____

4 Patient's Doctors – Please Tell Us Whom To Thank And With Whom to Coordinate Your Care

My:	Physician's Name:	Phone Number	City	Date Last Seen	Referred me:	I was sent or came in especially for:
Family/ Primary	_____	_____	_____	___/___/___	☐**Y** ☐**N**	**2nd Opinion / Surgcl Eval / Consult**
Specialist	_____	_____	_____	___/___/___	☐**Y** ☐**N**	**2nd Opinion / Surgcl Eval / Consult**
Other Podiatrist	_____	_____	_____	___/___/___	☐**Y** ☐**N**	**2nd Opinion / Surgcl Eval / Consult**

5 For Doctor's Use – Observations & Comments

☐ Patient was O assisted in completion of this record by or was O unable to complete without the help of _____

☐ Additional information obtained from O Family/Care givers and/or O Physician(s)_____

☐ Lab Reports and/or ☐ Previous Medical Records were reviewed. ☐ X-rays brought by patient from _____ were reviewed.

Elaborations: _____

_____

_____

_____

_____

I have reviewed the information provided above_____. ☐ My annotations to patient's entries are marked in: _____

Doctor's Signature **X** _____Date____/____/_____ **(INK COLOR)** ☐ See Additional Documentation

☐ **Only Changes To The Previous History Information Are Noted**