

PATIENT IDENTIFICATION AND CONTACT INFORMATION

Patient Acct. # _____

First Name: _____ MI: _____ Last Name: _____				Your type of Job Activity / Occupation: _____			I prefer to be addressed as: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	
Soc. Sec. No.: _____		Sex M / F	Age	Birth Date: / /	Shoe Size:	Weight:	Height:	I prefer to be addressed by: <input type="checkbox"/> First Name <input type="checkbox"/> 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 Phone No.: _____		

COMPREHENSIVE PATIENT MEDICAL HISTORY

Have you had/been treated for:

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

SYSTEMS REVIEW (circle)

General Health: Good Fair Poor
 Weight Change last 6 months: Loss Gain total lbs. _____
 Severe reaction to anesthesia: No Yes
 Tendency to bleed excessively: No Yes

Do you have or have you ever been treated for:

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

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? Yes No

Are you now under active chemotherapy? Yes No

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

When noting frequency: A = As needed x/ = times per D = day W = Week

List: Medications Dose? How Often? For Treatment of?

	A	x/	D	W	
	A	x/	D	W	
	A	x/	D	W	
	A	x/	D	W	
	A	x/	D	W	

Are you taking your medications as prescribed? Yes No

Drug Allergies and Reactions:

My: Physician's Name: City Date Last Seen

Family/Primary _____ / /

Specialist _____ / /

Other Podiatrist _____ / /

SOCIAL HISTORY:

Occupation: _____ How long? _____

City where you reside: _____ Married? _____

Persons with whom you live:

Spouse ___ Friend ___ Child ___ Live Alone ___

Percent of waking hours spent on your feet? 20% 40% 60% 80% 100%

List the sports/type of dance you are active in:

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

FAMILY MEDICAL HISTORY:

Mother: Alive Deceased

Father: Alive Deceased

Siblings:

List relationship to you of family members who have had:

Diabetes _____ Foot Problems _____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

PHYSICAL EXAM: To be completed by nurse.

Weight _____ B/P _____ Pulse _____

Abnormalities:

Patient Signature _____ Date _____

MD Initials & Date					