Patient Health and History

Today's Date: _____

Legal First Name: _____ M.I._____ Legal Last Name: _____

What is the reason for your visit to the podiatrist today? _____

How long has this condition been present? #_____ ☐days ☐ weeks ☐ months ☐ years

Is this condition due to an injury from a motor vehicle accident or work related injury? ☐ Yes ☐ No

Have you ever seen a doctor for this condition before coming here today? ☐ Yes ☐No

How painful or bothersome is this problem on a scale of 1-10 with 10 being severe? _____

Does it interfere with your daily activities? ☐Yes ☐No

How would you describe the discomfort? ☐Sharp ☐Stabbing ☐Throbbing ☐Aching ☐Tingling ☐No pain
☐Other: _____

Where exactly is the area of discomfort/concern? ☐Right ☐Left ☐Toes ☐ Foot ☐ Ankle ☐ Leg

Does the discomfort/area of concern ☐ radiate ☐ stay in one place?

Have you tried anything that improves your discomfort/area of concern? ☐ Yes ☐ No
If yes, what made it better? _____
What makes it worse? _____

Is the problem getting ☐better ☐worse ☐staying the same?

Have you noticed anything that may have caused this pain/area of concern? ☐Yes ☐No
If yes, what? _____

Review of Systems
Do currently have or recently experienced:

☐weight loss
☐weight gain
☐chronic pain
☐fever or chills
☐nausea or vomiting
☐blurry vision
☐headaches
☐difficulty hearing
☐shortness of breath
☐chest pain
☐swelling
☐calf/leg pain or cramps
☐abnormal bruising
☐numbness
☐weakness
☐balance problems
☐diabetes
☐thyroid disorder
☐joint pain/swelling
☐muscle pain/ache
☐anxiety
☐depression
☐sores that don't heal
☐lesions changing size, shape or color

Patient Name: _____

Do you have any allergies to the following:

☐No Know Allergies ☐Local Anesthetic ☐Latex
☐Adhesive Tape ☐Iodine or Shellfish ☐Other: _____

What kind of reaction do you have? ☐Itching ☐ Rash ☐Hives ☐Shortness of Breath ☐Anaphylaxis
☐Other: _____

What medications are you currently taking including prescription, over the counter and vitamins?

Medication Name Dosage How often do you take it?

_____

_____

_____

_____

_____

_____

_____

Please indicate if you have had any of the following:

☐AIDS/HIV
☐Anemia
☐Angina
☐Ankle Pain
☐Arthritis _____
☐Artificial Heart Valve
☐Artificial Joint
☐Athletes Foot
☐Asthma
☐Back Problems
☐Bleeding Disorder
☐Bunions
☐Cancer _____
☐Chemical Dependency
☐Chemotherapy
☐Chest Pain
☐Circulatory Problems
☐Corns and Calluses
☐Diabetes
☐Epilepsy
☐Fainting
☐Fibromyalgia
☐Flat Feet
☐Foot or Leg Cramps
☐Gout
☐Headaches
☐Heart Disease
☐Heel pain
☐Hemophilia
☐Hepatitis or Jaundice
☐High Blood Pressure
☐Ingrown Toenails
☐Kidney Problems
☐Liver Disease
☐Low Blood Pressure
☐Numbness in feet or legs
☐Neuropathy
☐Plantar Warts
☐Phlebitis
☐Psychiatric Care
☐Radiation Treatment
☐Rash
☐Respiratory Disease
☐Rheumatic Fever
☐Shortness of Breath
☐Sinus Problems
☐Stroke
☐Swelling in ankles or feet
☐Tired Feet
☐Ulcers
☐Varicose Veins
☐Weight Loss, unexplained

Patient Name: _____

List any previous surgeries: _____

_____

List any previous hospital stays: _____

_____

Family History:
Mother ☐Alive ☐Deceased Medical conditions: _____
Father ☐Alive ☐Deceased Medical conditions: _____
Sister ☐Alive ☐Deceased Medical conditions: _____
Brother ☐Alive ☐Deceased Medical conditions: _____
Maternal Grandparents ☐Alive ☐Deceased Medical conditions: _____
Paternal Grandparents ☐Alive ☐Deceased Medical conditions: _____

Social History:
Do you exercise? ☐Yes ☐No
If yes, how many times a week? _____

Smoking status? ☐Non-Smoker ☐ Occasional Smoker ☐Former Smoker
☐Everyday _____#packs/day _____#of years smoked

Recreational drugs? ☐Yes ☐No If yes, how frequently? daily occasionally For how long? _____

Alcohol use? ☐Yes ☐No If yes, daily occasionally How much? _____

Are you pregnant? ☐ Yes ☐ No

Height: _____ft _____in Weight: _____lbs Shoe size: _____

I certify that the above information is true to the best of my knowledge. I nearby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Patient or Guardian Signature Date

_____ _____
Witness Signature Date