NAME: ____________________________________________

## MEDICAL HISTORY

Place a mark on the "Yes" or "No" to indicate if you have had any of the following:

| Condition | Yes | No | Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ❑ Yes | ❑ No | Congestive Heart Failure | ❑ Yes | ❑ No | High Blood Pressure | ❑ Yes | ❑ No |
| Alcoholism | ❑ Yes | ❑ No | Diabetes, How Long____ | ❑ Yes | ❑ No | Kidney Problems | ❑ Yes | ❑ No |
| Anemia | ❑ Yes | ❑ No | Depression | ❑ Yes | ❑ No | Liver Disease | ❑ Yes | ❑ No |
| Angina/Chest Pain | ❑ Yes | ❑ No | Hearing Loss | ❑ Yes | ❑ No | Phlebitis | ❑ Yes | ❑ No |
| Arthritis | ❑ Yes | ❑ No | Emphysema | ❑ Yes | ❑ No | Psychiatric Care | ❑ Yes | ❑ No |
| Artificial Heart Valve | ❑ Yes | ❑ No | Epilepsy | ❑ Yes | ❑ No | Rheumatoid Arthritis | ❑ Yes | ❑ No |
| Artificial Joints | ❑ Yes | ❑ No | Glaucoma | ❑ Yes | ❑ No | Sinus Problems | ❑ Yes | ❑ No |
| Asthma | ❑ Yes | ❑ No | Gout | ❑ Yes | ❑ No | Stroke | ❑ Yes | ❑ No |
| Back Problems | ❑ Yes | ❑ No | Heart Disease | ❑ Yes | ❑ No | Tuberculosis | ❑ Yes | ❑ No |
| Bleeding Problems | ❑ Yes | ❑ No | Heart Attack | ❑ Yes | ❑ No | Stomach Ulcers | ❑ Yes | ❑ No |
| Cancer | ❑ Yes | ❑ No | Hemophilia | ❑ Yes | ❑ No | Venereal Disease | ❑ Yes | ❑ No |
| Cataracts | ❑ Yes | ❑ No | Hepatitis or Jaundice | ❑ Yes | ❑ No | Other______________ | ❑ Yes | ❑ No |

## REVIEW OF SYMPTOMS: **Please circle any symptoms you CURRENTLY or RECENTLY have had.**

| | | |
|---|---|---|
| ❑None | **GENERAL** | Chills, Depression, Dizziness, Fainting, Fever, Headache, Loss of sleep, Loss of weight, Anxiety, Sweats |
| ❑None | **GASTROINTESTINAL** | Appetite poor, Constipation, Diarrhea, Excessive gas, Nausea, Rectal bleeding, Stomach Pain |
| ❑None | **EAR, NOSE, THROAT** | Bleeding gums, Blurred vision, Double vision, Hay fever/Sinusitis, Loss of hearing, Nose bleeds, Persistent cough |
| ❑None | **URINARY/KIDNEY** | Blood in urine, Frequent urination, Lack of bladder control, Painful urination, Difficulty urinating |
| ❑None | **SKIN** | Bruise easily, Hives, rash, Itching, Painful or large scars, Sore(s) that won't heal |
| ❑None | **RESPIRATORY** | persistent cough, shortness of breath, wheezing, bronchitis |
| ❑None | **CARDIOVASCULAR** | Chest pain, irregular heart beat, cramping in legs, swelling of legs, varicose veins |
| ❑None | **GENITO-URINARY** | ❑ MEN: Erection difficulty (ED), Sore on penis, Penis discharge<br>❑WOMEN: Hot flashes, Bleeding between periods, Date of last period________Are you pregnant? YES / NO, Number of children_____Number of pregnancies____ |

**HEALTH HABITS:** Check those you use and how much:

- ❑ Tobacco: ______________# packs/day?
  How many years?___________________
- ❑ Street/Illegal drugs__________________________
- ❑ Alcohol____________________________________
- ❑ Pain killers/Pain medications_________________

**FAMILY HISTORY:** Check if any blood relatives had any of the following.

- ❑ Arthritis
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Stroke/blood clots
- ❑ Problems with anesthesia

Shoe size_____________

Height: _____ft ______inches

Weight: ________lbs

My primary care physician is__________________________________Clinic______________________
I last had a physical on:_________________________
My current medications are: (please give list to receptionist)
_____________________________________________________________________________________
The pharmacy where I get my prescriptions filled is:______________________________________________
Surgeries I have had:
_____________________________________________________________________________________
Allergies (medications, environmental) ___________________________________________________
_____________________________________________________________________________________

NAME: ____________________________________________

Please state what is the PRIMARY concern you are having with your toes, feet, ankles and/or legs.
________________________________________________________________________________________

How long ago did you first notice this? ___________________________________________________________

Do you recall any injury or change in activity prior to this? __ No __ Yes – please explain
__________________________________________________________ Date of injury or cause ____________

Have you received any medical treatment or advice for this condition? __No __
Yes______________________________________________________________________________________

Have you tried any self treatment or self care for this condition __ No __ Yes ___________________________
Have you ever been seen by a podiatrist before or had any foot or ankle surgery? __No __Yes
_________________________________________________________________________________________

DO YOU HAVE ANY OTHER CONCERNS YOU WOULD LIKE THE DOCTOR TO ADDRESS TODAY IF TIME ALLOWS?
__________________________________________________________________________________________

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor and his/her staff to administer and perform any care or procedures as may be deemed necessary in the diagnosis and/or treatment of my foot, ankle and/or leg. The doctor will discuss any proposed invasive procedures with me prior to my proceeding.

Patient's/Guardian's Signature______________________________________________Date______________