DR. WESLEY M. KOBAYASHI · DR. ERIC T. TRAVIS · DR. DANIEL E. RECALDE

PART 1

MEDICAL AND PODIATRIC HISTORY

PLEASE COMPLETE THE FOLLOWING INFORMATION WHICH WILL ASSIST IN DETERMINING AN ACCURATE DIAGNOSIS AND PROPER COURSE OF TREATMENT

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Date of Last Physical Exam: _____ **By Whom:** _____

Current Primary Care Physician & City: _____

Other Current Medical Specialists & City: _____

Current Medications:

List of Medical Conditions For Which You Are Currently Being Treated:

Are You Allergic or Sensitive to:

- ☐ NOVOCAINE
- ☐ ADHESIVE TAPES
- ☐ IODINE
- ☐ FOODS
- ☐ PENICILLIN
- ☐ OTHER MEDICATIONS

Previous Surgeries/Hospitalizations: Year & Reason:

Are You a Smoker: ☐ YES ☐ NO

HOW MANY YEARS: _____ PACKS/DAY: _____

Do You Consume Alcohol: ☐ YES ☐ NO

AMOUNT/WEEK: _____

Do You Drink Coffee: ☐ YES ☐ NO

CUPS/DAY: _____

Please Check Any of the Following Conditions You Have Had:

- ☐ HEART PALPITATIONS
- ☐ CHEST PAIN
- ☐ RHEUMATIC FEVER
- ☐ BREATHING PROBLEMS
- ☐ ASTHMA
- ☐ EMPHYSEMA
- ☐ HIGH BLOOD PRESSURE
- ☐ LIVER DISEASE
- ☐ HEPATITIS
- ☐ KIDNEY DISEASE
- ☐ CIRCULATION PROBLEMS
- ☐ HARDENING OF THE ARTERIES
- ☐ STROKE
- ☐ ANEMIA
- ☐ BLEEDING GUMS
- ☐ DIABETES
- ☐ SUDDEN WEIGHT CHANGE
- ☐ ARTHIRITS
- ☐ GOUT
- ☐ STOMACH ULCERS
- ☐ FAINTING SPELLS
- ☐ NEUROLOGICAL PROBLEMS
- ☐ EPILEPSY
- ☐ CANCER
- ☐ POLIO
- ☐ VENEREAL DISEASE
- ☐ SUBSTANCE ABUSE
- ☐ ACQUIRED IMMUNE DEFICIENCY SYNDROME
- ☐ OTHER _____
- ☐ PREVIOUS TRAUMA OR FRACTURES (LIST YEAR AND INJURY) _____

Family History: (if deceased, list the cause of death)

If You Have Children, Please Complete

	AGE	HEALTH PROBLEM	AGE	SEX	HEALTH PROBLEM
Father					
Mother					
Brothers					
Sisters					

REASON FOR VISIT

Please briefly describe your foot, ankle or leg problems. Include which foot, R, L, or both; how long the problem has existed, and any previous treatment.

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PART 2

MEDICAL AND PODIATRIC HISTORY

PLEASE COMPLETE THE FOLLOWING INFORMATION WHICH WILL ASSIST IN DETERMINING AN ACCURATE DIAGNOSIS AND PROPER COURSE OF TREATMENT

Please Check Any of the Following Problems You Have Had:

Foot and Leg Conditions:

- ☐ ARCH PAIN
- ☐ BONE FRACTURE
- ☐ BOW LEGS
- ☐ BUNIONS
- ☐ BURNING
- ☐ CHILDHOOD CAST/BRACE
- ☐ COLDNESS
- ☐ FLAT FEET
- ☐ FOOT CRAMPS
- ☐ HAMMER TOES
- ☐ HEEL PAIN
- ☐ HIGH ARCHES
- ☐ KNEE PAIN
- ☐ KNOCKED KNEES
- ☐ LEG CRAMPS
- ☐ LOW BACK PAIN
- ☐ NERVE INJURY
- ☐ NUMBNESS
- ☐ OUT TOEING
- ☐ IN TOEING
- ☐ PIGEON TOES
- ☐ SHIN SPLINTS
- ☐ SHOE WEAR PROBLEMS
- ☐ SPRAINS
- ☐ STIFFNESS
- ☐ SWELLING
- ☐ SWELLING
- ☐ UNEQUAL LEG LENGTH
- ☐ VARICOSE VEINS
- ☐ WEAK ANKLES
- ☐ OTHER

Toenail Problems:

- ☐ BRITTLE
- ☐ CURVED
- ☐ DEFORMED
- ☐ DISCOLORED
- ☐ FUNGUS
- ☐ INGROWN
- ☐ THICK
- ☐ OTHER _____

Foot and Skin Problems:

- ☐ CORNS
- ☐ CRACKING
- ☐ DRYNESS
- ☐ FOOT ODOR
- ☐ FUNGUS
- ☐ GROWTHS
- ☐ HARD CORNS
- ☐ ITCHING
- ☐ MOIST SKIN
- ☐ SOFT CORNS
- ☐ SHOE WEAR PROBLEMS
- ☐ EXCESSIVE PERSPIRATION
- ☐ BRUISES OR CUTS AS A CHILD
- ☐ EXCESSIVE PERSPIRATION
- ☐ CALLUSES
- ☐ WARTS
- ☐ OTHER _____

Do Other Members of Your Family Have Foot Problems: (Grandparents, Parents, Siblings, Children)

HOW MANY HOURS A DAY ARE YOU ON YOUR FEET?	TYPE OF SHOE USUALLY WORN AT WORK?	WORK SURFACE?	DO YOU WEAR:	SHOE SIZE:
	☐ OXFORD ☐ ATHLETIC SHOE ☐ SLIP-ON ☐ BOOTS ☐ HIGH HEELS ☐ OTHER	☐ CARPET ☐ UNEVEN ☐ LINOLEUM ☐ CONCRETE ☐ OUTDOORS	☐ PRESCRIPTION ORTHOTICS ☐ OVER-THE-COUNTER SUPPORTS ☐ OTHER SUPPORT DEVICES	

Regular Exercise Activities and Shoes used:
(Please List Activity and Briefly Describe Shoe Used: Walking, Running, Aerobic Dance, Tennis, Golf, etc.)

Have You Previously Been Treated by a Podiatrist ☐ Y ☐ N
For What Problem?

Have You Ever Has Foot Surgery ☐ Y ☐ N
Describe:

Remarks:

_____

_____

If Your Condition is Due to an Accident, Please Complete: WHERE DID THE ACCIDENT HAPPEN? ☐ WORK ☐ HOME ☐ AUTO

IF INJURY HAPPENED AT WORK, EMPLOYER'S NAME: _____

WHO DID YOU REPORT IT TO AND PHONE NUMBER: _____

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

DATE OF INJURY: _____

NAME OF ADJUSTER: _____

CASE AND/OR FILE NUMBER: _____

PHONE NUMBER: _____