

List Any Known Allergies _____

List Current Medications _____

Are you currently taking a Birth Control Pill? Yes _____ No _____

Pharmacy Name _____ Pharmacy Ph# (_____) _____ - _____

Family Physician _____ Date Last Seen _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years?
Yes _____ No _____

If Yes, please explain _____

Height: _____ Ft. _____ Inches / Weight: _____ / Shoe Size: _____

SOCIAL HISTORY

Cigarette Use _____ How Much? _____

Chewing Tobacco _____

Alcohol Use _____ How Much? _____

Marital Status (circle one)

Single Married Separated Divorced Widowed

Occupation _____

FAMILY HISTORY (Circle all that apply) (Relationship to You)

Arthritis Cancer Diabetes Gout

Heart Problems Kidney Disease Psychiatric Illness Stroke

PAST SURGICAL HISTORY

List all Surgeries you have had: _____

PAST MEDICAL HISTORY (Circle All That Apply) or (none)

CARDIOVASCULAR

Heart Disease
Hypertension

ENDOCRINE HISTORY

Diabetes
Hypothyroidism
Obesity

HEMATOLOGIC HISTORY

Blood Clotting Abnormalities
Hepatitis
Sickle Cell
Jaundice

GASTROINTESTINAL HISTORY

Ulcer

PSYCHIATRIC HISTORY

Depression
History Psychiatric Problems

RESPIRATORY HISTORY

Asthma
COPD

NEUROLOGIC HISTORY

Neuropathy
Seizure
Stroke

MUSCULOSKELETAL HISTORY

Arthritis Conditions
List _____
Back Pain
Gout

CHILDHOOD ILLNESSES

Asthma

REVIEW OF SYSTEMS (Circle all that apply) or (none)

ALLERGIC / IMMUNOLOGIC

Hepatitis
HIV/AIDS

CARDIOVASCULAR

Ankle Swelling
Cold Feet
Shortness of Breath

CONSTITUTIONAL SYMPTOMS

Unexpected Weight Changes
Anxiety

RESPIRATORY

Difficulty Breathing
Chest Pain
Shortness of Breath
Sleep Apnea

EYES

Blurred Vision
Dry Eyes

NEUROLOGICAL

Balance Problems
Vertigo
Numbness
Paresis (muscle weakness)

EAR, NOSE, MOUTH, THROAT

Ear Pain
Ringing in the Ears
Nasal Pain
Mouth Pain

ENDOCRINE

Diabetes
Hypothyroidism

GASTROINTESTINAL

Chronic Diarrhea
Gastrointestinal Ulcers
Stomach Problems

HEMATOLOGIC

Blood Clotting Problems
Sickle Cell

INTEGUMENTARY

Athlete's Foot
Foot Ulcer
Leg Ulcer
Skin Cancer

GENITOURINARY

Chance of Pregnancy
Painful Urination

MUSCULOSKELETAL

Back Pain
Joint Pain
Muscle Pain
Gout Attack

PSYCHIATRIC

Addiction to Alcohol
Addiction to Drugs
Depression
Panic Attacks

PODIATRY HISTORY

What problem brings you to our office? _____

How long has this existed? _____

Can you recall any event when this started _____?

Has this condition been getting better, worse or the same? _____

Treatments you have done in the past _____

Are your symptoms worse after standing?	Yes _____	No _____
Are your symptoms worse after walking?	Yes _____	No _____
Are your symptoms worse after wearing shoes?	Yes _____	No _____
Do your symptoms affect your work or sports activities?	Yes _____	No _____
Are you required to wear special foot gear?	Yes _____	No _____
Do you spend more than 50% standing at work?	Yes _____	No _____
Do you experience burning, numbness or tingling in your feet or legs?	Yes _____	No _____
Do you experience corns or calluses?	Yes _____	No _____
Has anyone in your family ever had foot problems similar to yours?	Yes _____	No _____
Have you been treated by a doctor for your foot condition?	Yes _____	No _____

If Yes, please describe: _____

Former Podiatrist: _____

Name

Why and when did you last see a podiatrist? _____

Patient's Signature: _____ Date: _____

Whom may we "Thank" for referring you to our office? _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of me.

Signature: _____ Date _____

Guardian's Signature (if under 18 yrs. of age) _____