Patient Medical History

Patient Name_____ **Date of Birth**_____

Podiatry History

What is the reason for your visit today? _____

When did this problem begin? _____

Describe anything that may have caused it:_____

Have you seen another doctor for this problem? ❑No ❑Yes _____

Describe any previous treatment or home remedies?_____

Current pain level related to this condition *(circle one)*: 0 1 2 3 4 5 6 7 8 9 10
No pain Worst Pain

Social History

Height: _____ Weight: _____ Shoe Size: _____ Do you wear orthotics or a shoe insert? ❑No ❑Yes_____
List any regular sports or exercise activities:_____

Do you now or did you ever smoke cigarettes? ❑No ❑Yes # Packs/Day: _____ #Years: _____
If you have quit smoking, when?_____
Do you drink alcoholic beverages? ❑None ❑Occasionally ❑Weekly #_____ ❑Daily #_____
Do you use "recreational" drugs (marijuana, cocaine, heroin, etc.)? ❑No ❑ Yes: _____
Do you currently or have a history of opioid dependency? ❑No ❑ Yes: _____

Surgical History

Procedure	Year
❑ Orthopedic *(joint repair, fractures)*	
❑ Vascular *(leg bypass, aneurysm, vein stripping)*	
❑ Neurologic *(spinal fusion, disk repair)*	
❑ Cardiovascular *(bypass, valve repair, pacemaker)*	
❑ Other:	

Family History

Has anyone in your *immediate* family been treated for:

	Relation	☑ Deceased
❑ Diabetes		❑
❑ Cancer:		❑
❑ Bleeding disorders		❑
❑ Other:		❑

Past Medical History

Have you ever been treated **by a doctor** for: *(check all that apply)*

- ❑ Diabetes – Type I or 2
- ❑ Phlebitis or Blood clots (DVT)
- ❑ Thyroid disorder
- ❑ Liver disease
- ❑ Congestive heart failure (CHF)
- ❑ Anxiety or Depression
- ❑ Parkinson's Disease
- ❑ Skin disorder_____
- ❑ Neuropathy
- ❑ Dementia or Alzheimer's
- ❑ High cholesterol
- ❑ Kidney disease
- ❑ Heart attack (MI)
- ❑ Fibromyalgia
- ❑ Seizure disorder
- ❑ Other(s):
- ❑ Peripheral vascular disease
- ❑ Gout
- ❑ High Blood Pressure
- ❑ Cancer_____
- ❑ Stroke – CVA or TIA
- ❑ Arthritis – osteo or rheumatoid
- ❑ Glaucoma
- ❑ Lymphedema
- ❑ Asthma or COPD
- ❑ Anemia
- ❑ AIDS or HIV+
- ❑ Atrial Fibrillation (AFib)
- ❑ GERD or Peptic Ulcers
- ❑ Cataracts

Patient Medical History

Important Contacts

Primary Care Physician:	Phone:	**Date of Last Visit:
Preferred Pharmacy:	Pharmacy Location:	
Emergency Contact:	Relation:	Phone:

Medications

****include any over-the-counter medications and vitamins*

Medication Name	Dosage

Allergies

Allergen (drug, food, etc.)	Reaction

Review of Systems

Please check which of the following symptoms, if any, you are *currently* experiencing:

❑ fatigue	❑ fever or chills	❑ chronic pain	❑ weight gain	❑ weight loss
❑ blurred vision	❑ dry eyes	❑ eye pain	❑ eye glasses	❑ contact lenses
❑ decreased hearing	❑ ringing in ears	❑ sore throat	❑ nose bleed	❑ headache
❑ chest pain / tightness	❑ calf pain with walking	❑ calf cramping	❑ leg or ankle swelling	❑ blue or purple toes
❑ short of breath	❑ cough - dry	❑ cough - productive	❑ sleep apnea	❑ wheezing
❑ abdominal pain	❑ constipation	❑ diarrhea	❑ heartburn	❑ nausea or vomiting
❑ post menopause	❑ irregular periods	❑ genital sores	❑ frequent urination	❑ painful urination
❑ low back pain	❑ joint pain	❑ joint swelling	❑ muscle pain	❑ muscle weakness
❑ dry or scaly skin	❑ loss of hair growth	❑ mole changes	❑ skin rash	❑ open wound or ulcer
❑ loss of balance	❑ sciatica	❑ tingling or numbness	❑ burning pain of feet	❑ tremors
❑ anxious or nervous	❑ confused	❑ memory loss	❑ sad or depressed	❑ hallucinations
❑ cold intolerance	❑ heat intolerance	❑ excessive hunger	❑ excessive thirst	❑ cold feet and hands
❑ hives	❑ nasal discharge	❑ eye redness	❑ itchy skin	❑ sinus pressure

I give permission to the doctor to examine and administer such treatments and perform procedures as may be deemed medically necessary in the diagnosis and treatment of my foot or ankle condition.

Patient Name_____ **DOB**_____

Responsible Party (if other than patient)_____ **Relationship**_____

Signed_____ **Date**_____