

Patient Name _____ Date _____

Please indicate which foot problems you now have or have had by checking yes or no

Ankle Pain	<input type="checkbox"/> yes <input type="checkbox"/> no	Flat feet	<input type="checkbox"/> yes <input type="checkbox"/> no	Ingrown toenails	<input type="checkbox"/> yes <input type="checkbox"/> no
Athlete's Foot	<input type="checkbox"/> yes <input type="checkbox"/> no	Foot or leg cramps	<input type="checkbox"/> yes <input type="checkbox"/> no	Plantar warts	<input type="checkbox"/> yes <input type="checkbox"/> no
Bunions	<input type="checkbox"/> yes <input type="checkbox"/> no	Heel pain	<input type="checkbox"/> yes <input type="checkbox"/> no	Tired feet	<input type="checkbox"/> yes <input type="checkbox"/> no
Corns and Calluses	<input type="checkbox"/> yes <input type="checkbox"/> no	Cramps or numbness in feet or legs	<input type="checkbox"/> yes <input type="checkbox"/> no	Swelling in ankles or feet	<input type="checkbox"/> yes <input type="checkbox"/> no
Other _____					

Have you ever been to a Podiatrist before?

Yes No

If yes, please list

Name _____

Last Visit _____

Treatment _____

Height _____ Weight _____ Shoe Size _____

Athletic activities in which you participate

(Please list and indicate frequency.)

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____ Pks / Yrs _____

Drug Usage _____

PERSONAL & FAMILY HISTORY

Please check appropriate box.

	<i>Personal</i>	<i>Family</i>	<i>If yes, please indicate relationship</i>
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Hypertension	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Heart Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Gout	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Head Trauma	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Lung disease	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Liver disease	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Hepatitis	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Ulcers or Stomach Problems	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
HIV	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Depression/Anxiety	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Rheum. Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Osteoarthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Fibromyalgia	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Bleeding Problem	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Neurological Problems	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Skin Disorders	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____

Allergies - Reaction or drug side effects:

___ None	___ Aspirin	___ Penicillin	___ Sulfa	___ Topical Meds	___ Local Anesthetic
___ Pain Medication	___ Cortisone	___ Tape	___ Iodine	(internal or external)	___ Other

What antibiotics or pain meds have you used in the past? _____

Current Medications: (attach list if you have)

Drug	Dose
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Past Surgeries & Hospitalizations; dates:

(List most recent first)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____