Welcome to our office! This information is important for our records and your health.

Name: ________________________, ________________________ **Age:** ______ **Male Female Date:** __________
(last) (first) (circle)

Are you a diabetic? (circle) Yes No If yes, are you treated with: insulin, pills, diet?

If yes, how many years have you been a diabetic? ___________ Average blood sugar: _________________

What is your main foot problem today? (right, left, or both feet) ____

____

Where is your pain or problem located? ____

How severe is the pain or problem? (circle) none minimal moderate severe Other: _____________________

How long have you had this problem? (circle) 1 2 3 4 5 6 7 8 9 _______ days, weeks, months, years.

When is the problem worse? (circle) first out of bed, AM, PM, during/after work. Other: _________________

How would you describe this pain? (circle) shooting, burning, aching, throbbing, bruised, sharp, dull, itching, tingling, numbness, dull pain, tenderness. Other: ____

What makes it better? ____

What caused the problem or makes it worse? ____

How has it been treated? (circle) ice, rest, pads, ibuprofen, tylenol. Other: ___________________________

Do you have any other foot problems that need attention? __________________________________

____

Allergies: (circle) No known allergies, penicillin, sulfa, aspirin, tape, codeine, iodine, novocaine, latex.

List others: ____

List all medications: None or: ____

____

List all major injuries: None or: ____

List all major illnesses: None or: ____

____

List all surgeries or hospitalizations: None or: ____

____

Is there a family history of these diseases? (circle) diabetes, arthritis, sickle cell, foot problems, heart or lung problems, cancer, keloid scars. Other: ____

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CC
HPI

____

Past

____

Fam

____

Social history: Are you (circle) single, divorced, married, widowed, other.

What is your employment? ______________________________

Do you smoke? Yes No How much per day? ____________

Do you drink alcoholic beverages? Yes No How much per week? ____________

Do you exercise regularly? Yes No Type of exercise? ____________

Women: # of children _____ Are you pregnant or breast-feeding? Yes No # of pregnancies?________

Please circle any symptoms or diseases that apply to you:

Constitutional (general health): weight loss weight gain fever chills fatigue nausea Other: ____________

Eyes/ears/nose/throat: glaucoma dizzy spells fainting spells impaired sight Other: ____________

Gastroint: ulcers stomach trouble weight loss liver problems hepatitis excessive thirst/hunger
Nausea vomiting alcoholism diarrhea bloody stools indigestion Other: ____________

Genitour: kidney disease prostate problems excessive urination kidney stones Other: ____________

Nervous: numbness tingling burning stroke weakness loss of feeling convulsions seizure fainting
spine disease brain disease paralysis cold feet sciatica Other:____________

Cardiovas: leg cramps varicose veins feet swell chest pain heart attack high blood pressure
leg pain when walking blood clots in legs bypass surgery on legs bad leg circulation
phlebitis mitral valve prolapse heart surgery rheumatic fever chest pain/angina
artificial valve pacemaker AICD-defibrillator implant Other: ____________

Derm: skin itching rash deformed nails psoriasis ulcerations eczema athletes foot
abrasions hives keloid scars Other: ____________

Mus-ske: gout rheumatoid arthritis stiffness bursitis muscle pain club foot fractures sprains
sciatica back pain joint pain osteoporosis fibromyalgia Other:____________

Resp: asthma pneumonia emphysema bronchitis lung problems wheezing coughing sleep apnea
shortness of breath tuberculosis Other:____________

Endocrine: Diabetes thyroid problems Other: ____________

Hematologic/Immune: anemia take coumadin take aspirin bleeding disorder sickle cell disease AIDS
HIV+ chronic fatigue syndrome on chemotherapy Other:____________

Psychiatric: depression nervousness sleeping difficulty mental illness Other:____________

Who is your primary physician? ____________

Did your physician refer you to our office? Yes No **When did you last see your doctor?** ____________

Patient Signature: ______________________ **Date:**____________

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Soc ______

ROS ______

All Reviewed by Dr. ______