Patient Name ________________________ DoB ____________ M / F Date ____________

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

Ankle Pain	□Yes	□No	Flat Feet	□Yes	□No	Ingrown Toenails	□Yes	□No
Athlete's Foot	□Yes	□No	Foot and Leg Cramps	□Yes	□No	Planter Warts	□Yes	□No
Bunions	□Yes	□No	Heel Pain	□Yes	□No	Tired Feet	□Yes	□No
Corns and Calluses	□Yes	□No	Cramps or Numbness in Feet or Legs	□Yes	□No	Swelling in Ankles or Feet	□Yes	□No

What brings you in today? ________________________

Current Pain Level: Left Foot / Right Foot Mild Moderate Severe

Have you ever been to a Podiatrist before?

□Yes □No

If yes, please list:

____

First Name ________________________

Last Name ________________________

Treatment ________________________

Height ________ Weight _______ Shoe Size ___________

Athletic activities in which you participate

____

____

Your Occupation ________________________

Cigarette/Tobacco Use ________________________

Years Smoked ________________________

Alcohol Use/Frequency ________________________

Drug Usage/Frequency ________________________

PERSONAL FAMILY HISTORY

Please check appropriate box

	Personal		Family	
Diabetes	□Yes	□No	□Yes	□No
Hypertension	□Yes	□No	□Yes	□No
Heart Disease	□Yes	□No	□Yes	□No
Gout	□Yes	□No	□Yes	□No
Head Trauma	□Yes	□No	□Yes	□No
Asthma	□Yes	□No	□Yes	□No
Lung Disease	□Yes	□No	□Yes	□No
Liver Disease	□Yes	□No	□Yes	□No
Hepatitis	□Yes	□No	□Yes	□No
Ulcers or Stomach Problems	□Yes	□No	□Yes	□No
HIV	□Yes	□No	□Yes	□No
Depression/Anxiety	□Yes	□No	□Yes	□No
Rheumatoid Arthritis	□Yes	□No	□Yes	□No
Osteoarthritis	□Yes	□No	□Yes	□No
Fibromyalgia	□Yes	□No	□Yes	□No
Bleeding Problem	□Yes	□No	□Yes	□No
Neurological Problems	□Yes	□No	□Yes	□No
Skin Disorders	□Yes	□No	□Yes	□No

Current Medication Drug/Dose

____

____

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____

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____

Past Surgeries & Hospitalizations/Dates

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Allergies – Reactions or Drug Side Effects:

_____ None _____ Aspirin _____ Penicillin _____ Sulfa _____ Topical Meds _____ Local Anesthetic
_____ Pain Medication _____ Cortisone _____ Tape _____ Latex _____ Iodine (Internal or External) _____ Other

Any Other Pertinent Information: ________________________

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