

Patient Name _____ DoB _____ M / F Date _____

Please indicate which foot problems you have had, and what you are experiencing now 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 and Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Planter 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

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: _____

Athletic activities in which you participate

First Name _____

Last Name _____

Treatment _____

Your Occupation _____

Cigarette/Tobacco Use _____

Years Smoked _____

Alcohol Use/Frequency _____

Drug Usage/Frequency _____

Height _____ Weight _____ Shoe Size _____

Allergies – Reactions or Drug Side Effects:

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

PERSONAL FAMILY HISTORY

Please check the appropriate box

	Personal	Family	Current Medication	Drug/Dose
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	_____	
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	_____	
Herpes/STD	<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	_____	
Rheumatoid Arthritis / Gout	<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	_____	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

Type: _____

Past Surgeries & Hospitalizations/Dates

Any Other Pertinent Information: _____

