

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 _____

Your Occupation _____

Last Name _____

Cigarette/Tobacco Use _____

Treatment _____

Years Smoked _____

Height _____ Weight _____ Shoe Size _____

Alcohol Use/Frequency _____

Drug Usage/Frequency _____

Allergies – Reactions or Drug Side Effects:

<input type="checkbox"/> None <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Topical Meds <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Pain Medication <input type="checkbox"/> Cortisone <input type="checkbox"/> Tape <input type="checkbox"/> Latex <input type="checkbox"/> Iodine (Internal or External) <input type="checkbox"/> Other

PERSONAL FAMILY HISTORY

Please check the appropriate box

	Personal	Family	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medication Drug/Dose
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	Past Surgeries & Hospitalizations/Dates
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: _____

Any Other Pertinent Information: _____

