



The doctor-patient relationship is based on trust and open communication. In order to make a valid diagnosis and provide you with beneficial care, the information you provide must be complete and truthful.

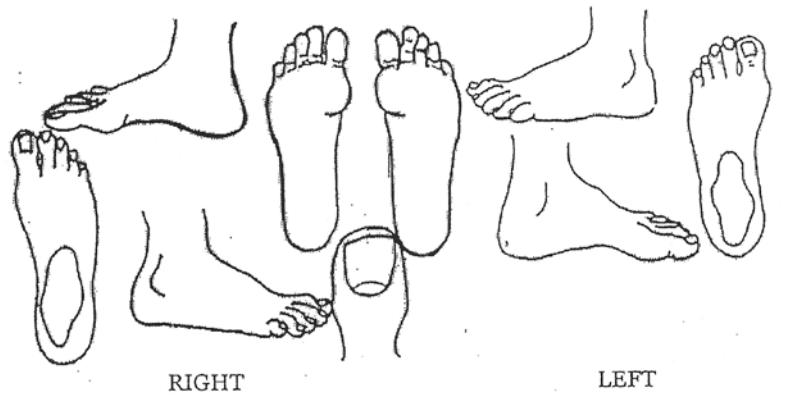
## PATIENT INFORMATION

Patient name: \_\_\_\_\_  
 Age \_\_\_\_\_ Race \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Gender \_\_\_\_\_ Shoe size/width \_\_\_\_\_ What type of shoes do you wear \_\_\_\_\_

## CHIEF COMPLAINT/HISTORY of PRESENT ILLNESS

Current foot/ankle problem: \_\_\_\_\_ Pain Scale (none) 1 2 3 4 5 6 7 8 9 10 (worst)

NATURE	LOCATION	COURSE
dull aching throbbing sharp stabbing burning tingling numbness	left right ankle foot 1st toe 2nd toe 3rd toe 4th toe 5th toe	intermittent constant random varied progressive sporadic



Duration (how long have you had the problem?) \_\_\_\_\_

Onset (how did it start?) \_\_\_\_\_

Aggravating Factors (what makes it worse?) \_\_\_\_\_

Treatment (what has been done?) \_\_\_\_\_

## MEDICINES

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## ALLERGIES

_____	_____
_____	_____
_____	_____

over please

## SOCIAL HISTORY

Occupation \_\_\_\_\_ disabled retired Hobbies \_\_\_\_\_

How do you spend most of your time? Sitting standing walking heavy lifting

Do you **smoke**? YES NO **drink**? YES NO use illicit **drugs**? YES NO drink **caffeine**? YES NO  
former chew tobacco social moderate heavy type \_\_\_\_\_ 1-2 3-4 5+

Have you received your **flu vaccine**? YES NO Have you received your **pneumococcal vaccine**? YES NO

## FAMILY MEDICAL HISTORY

Father alive deceased PastMedHx \_\_\_\_\_  
Mother alive deceased PMH \_\_\_\_\_  
# of brothers \_\_\_\_\_ PMH \_\_\_\_\_  
# of sisters \_\_\_\_\_ PMH \_\_\_\_\_

## YOUR PAST MEDICAL HISTORY

Do you have or have you had any of the following conditions? (circle those that apply)

acne	diabetes type 1 type 2	liver disease
anemia	epilepsy	lower back pain/problems
anxiety	fibromyalgia	malignant melanoma
arthritis	GI bleeding	melanoma
artificial joint replacement	GI reflux/GERD	mitral valve prolapse
asthma	gout	muscular dystrophy
autoimmune dz (HIV/AIDS)	heart attack	pulmonary fibrosis
basal cell carcinoma	heart disease	peripheral vascular disease
bleeding disorders	hepatitis A B C D E	Raynaud's
cancer _____	hernia	rheumatoid arthritis
cataracts	high blood pressure	seizures
Charcot foot	high cholesterol	squamous cell carcinoma
COPD/emphysema	hyperthyroid	stroke
CRPS/RSD	hypothyroid	warts
depression	kidney disease	OTHER _____

Are you diabetic? YES NO

If yes, how long? \_\_\_\_\_ Controlled by? DIET PILLS INJECTIONS  
If yes, what was your last glucose reading \_\_\_\_\_ taken when \_\_\_\_\_ A1c \_\_\_\_\_  
do you walk barefoot YES NO  
do you check your feet daily? YES NO  
do you wear diabetic shoes? YES NO

## PAST SURGICAL HISTORY & HOSPITALIZATIONS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Date last seen: \_\_\_\_\_  
Name of Former Podiatrist: \_\_\_\_\_ Date last seen: \_\_\_\_\_

Whom may we thank for referring you to our office/How did you find us? \_\_\_\_\_