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 _____

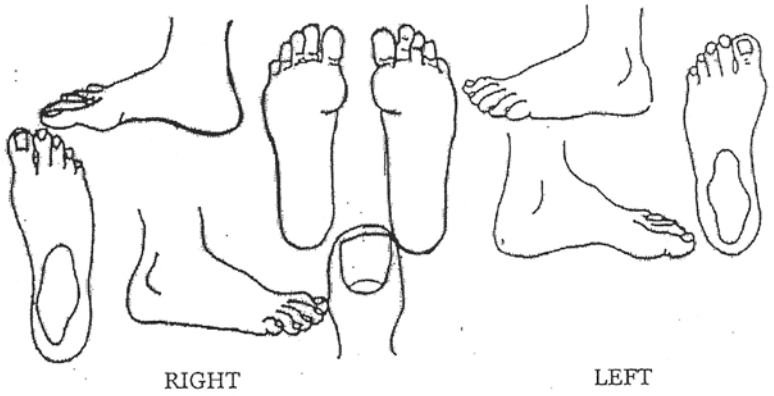
Gender _____ Shoe size/width _____ What type of shoes do you wear _____

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