

PATIENT MEDICAL INFORMATION

Name _____ Date _____ Birth Date _____

Shoe Size _____ Height _____ Weight _____ Age _____

What is your main foot complaint? _____

When did this problem first start? _____

Type of Pain: (*check all that apply*)
 Sharp Dull Burning Numbness
 Throbbing Radiating General Local

What eases pain? _____

What makes pain worse? _____

What have you done to help this problem? _____

If another doctor treated you for this problem, what was done? _____

Medications:

What are your current medications? (List may be attached) _____

Pharmacy Name and Location: _____

Please check any of the following you are currently taking:

Echinacea Garlic Ginger Gingko Biloba St. John's Wort Ephedra
 Kava kava Feverfew Hoodia Any other weight loss pills _____

Previous Surgeries:

Date:

Please note any complications: _____

Do you have any implanted metal devices? (e.g. pacemaker, stent, etc.)

NO YES (please list) _____ **Date of implant:** _____

Immunization Status: Tetanus: Current Over 5 years Over 10 years Unknown

Flu Shot: Yes No Hepatitis B: (3 doses) Received Never received

Allergies: (Please check any that apply)

- I have no known allergies
- Penicillin Sulfa drugs Other antibiotics (Please specify) _____
- Aspirin Codeine Other pain medications _____
- Other anti-inflammatory medications (NSAIDS) _____
- Local anesthetics General anesthetics Latex Iodine/Shellfish
- Other medication allergies _____

Medical history: Please check (X) any of the following illnesses you have ever had:

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney problems/Dialysis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes: (Please check) | <input type="checkbox"/> Lung disease: (Please check) |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Insulin | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Arthritis: (Please check) | <input type="checkbox"/> Non-insulin | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Rheumatoid | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Muscle disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Bladder dysfunction | <input type="checkbox"/> Fracture history | <input type="checkbox"/> Prostate conditions |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> GERD/acid reflux | <input type="checkbox"/> Psychiatric conditions |
| <input type="checkbox"/> Cancer history: (please check) | <input type="checkbox"/> Gout | <input type="checkbox"/> Restless leg syndrome |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bone | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Thrombophlebitis/blood clots |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Hernia | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Pancreatic | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Ulcer (GI) |
| <input type="checkbox"/> Skin | <input type="checkbox"/> High Blood Pressure (Hypertension) | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Claudication/leg pain when walking | <input type="checkbox"/> High Cholesterol | |

Please list any other conditions you have that are not listed above: _____

Social History:

- Single Divorced **Alcohol Use:** _____ drinks per: Day Week I do not drink alcohol
- Married Widowed **Tobacco Use:** _____ packs/day for _____ Years I do not smoke or use tobacco

Employment status: Full-time Part-time Self-employed Retired Disabled Homemaker Unemployed

Athletic activities: _____

Family Medical History: Please check the conditions that your Mother or Father have or have had.

- | | | | | | |
|---|---------------------------------|---------------------------------|--------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | Mother | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | Father | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | | | |
| <input type="checkbox"/> DVT | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | | | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | | | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | | | |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | | | |
- I do not know any of my family history (adopted)

Patient Signature _____ **Date** _____
(If a minor, Parent or Guardian Signature)