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) ____

____

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:

☐ Allergies
☐ Anemia
☐ Anxiety disorder
☐ Arthritis: (Please check)
- ☐Rheumatoid
- ☐Osteoarthritis

☐ Asthma
☐ Bladder dysfunction
☐ Bleeding Disorders
☐ Cancer history: (please check)
- ☐Breast
- ☐Lung
- ☐Prostate
- ☐Bone
- ☐Brain
- ☐Pancreatic
- ☐Skin

☐ Depression

☐ Diabetes: (Please check)
- ☐Insulin
- ☐Non-insulin

☐ Drug abuse
☐ Epilepsy
☐ Eye problems
☐ Fracture history
☐ GERD/acid reflux
☐ Gout
☐ Headaches/Migraines
☐ Hearing problems
☐ Heart disease
☐ Hepatitis ☐A ☐B ☐C
☐ Hernia
☐ HIV/Aids
☐ High Blood Pressure (Hypertension)
☐ High Cholesterol
☐ Kidney problems/Dialysis

☐ Lung disease: (Please check)
- ☐Bronchitis
- ☐Emphysema
- ☐COPD

☐ Muscle disease
☐ Polio
☐ Prostate conditions
☐ Psychiatric conditions
☐ Restless leg syndrome
☐ Skin problems
☐ Sleep Apnea
☐ Stroke
☐ Thrombophlebitis/blood clots
☐ Thyroid disorder
☐ Ulcer (GI)
☐ Varicose veins

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

____

Social History:

Alcohol Use: Do you drink ☐ Daily ☐ Weekly ☐ Monthly? How many drinks _______ How often do you have 6 or more drinks
at one time ☐ Daily ☐ Weekly ☐ Monthly? ☐ I do not drink alcohol

Tobacco Use: ☐Everyday ☐Sometimes (but not every day) ☐ **I do not smoke or use tobacco**
How many cigarettes in a day ☐5 or less ☐6-10 ☐11-20 ☐ 21-30 ☐31 or more

How long after you wake up do you have your 1st cigarette ☐within 5 min ☐6-30min ☐31-60 min
Are you interested in quitting: ☐yes ☐No

Marital Status_______________
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.*

☐ Diabetes	☐ Mother	☐ Father
☐ Hypertension	☐ Mother	☐ Father
☐ Heart Disease	☐ Mother	☐ Father
☐ DVT	☐ Mother	☐ Father
☐ Cancer	☐ Mother	☐ Father
☐ Stroke	☐ Mother	☐ Father
☐ Mental Illness	☐ Mother	☐ Father

Mother ☐Alive ☐Deceased
Father ☐Alive ☐Deceased

☐ **I do not know any of my family history (adopted)**

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