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_____?
☐ I do not drink alcohol
How often do you have 6 or more drinks at one time ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

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)