PATIENT HISTORY

*** Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you may have.**

NAME: _____

1) Vitals: Age: _____ Height: _____ Weight: _____ Shoe Size: _____

2) What is the MAIN COMPLAINT for today's visit? _____

_____

3) When did you first notice this PROBLEM? _____

4) Is this an injury? ____Yes ____No If Yes, when did it occur? ____/____/____

If Yes, did it happen at work? ____Yes ____No Are you claiming Workman's Comp? ____Yes ____No

5) Check ALL of the following that apply:

Type of Pain ___Burning ___Tingling ___Sharp ___Dull Ache ___Throbbing
___Shooting ___Stabbing ___Numbness ___ Electric ___ Itchy

When Painful ___Upon Standing ___During Walking ___After Walking
___During Sports ___Worse with Activity ___Better as Activity Continues
___Worse when standing ___With Shoes ___Without Shoes
___A.M ___P.M ___Lying in Bed ___Always

6) How painful is your condition? If **0** = "no pain" and **10** = "the worst pain you have ever experienced", please circle your pain level:

0 1 2 3 4 5 6 7 8 9 10

7) How has this affected your daily routine and what activities does this keep you from performing? _____

_____

8) Have you had foot care before? ____Yes ____No By whom and when: _____

_____

9) REVIEW OF SYSTEMS: Please circle all symptoms that may apply to you today

Constitutional: Chills, Fatigue, Fever, Night sweats, weight gain, weight loss

Cardiovascular: chest pain, claudication, varicose veins, swelling (pedal edema)

Respiratory: cough (chronic/acute), wheezing

Gastrointestinal: abdominal pain, acid reflux, bloating, constipation, diarrhea, heartburn, nausea, vomiting, stool change

Musculoskeletal: back pain, limb pain, joint stiffness

Intergumentary/Breast: acne, dry skin, fungal nail infection, rashes, warts, breast mass

Neurological: dizziness, fainting, headaches, memory loss, paresthesia, seizures, tremor, vertigo, weakness

Hematologic/Lymphatic: easy bruising, excess bleeding, hx of blood transfusion

Endocrine: hair loss, heat/cold intolerance, hot flashes, infertility, sweating/excessive sweating

Allergic/Immuniolgic: seasonal allergies, HIV risk factors

Psychiatric: anxiety, crying spells, depression, feeling stressed, mood swings, personality change, poor concentration, sleep disturbance

I am not experiencing any of the above symptoms.

10) Are you pregnant? ____Yes ____No **If yes:** How many months? _____

11) MEDICAL HISTORY *** Please check any of the following conditions that you have or have had in the past.**

Diabetes	Fibromyalgia	Tumors	Epilepsy	Nerve Conditions	Heart Problems
Arthritis	Gout	Asthma/COPD	Glaucoma	Stomach Ulcers	Skin Disorders
Tuberculosis	Anemia	Bursitis	Aids (HIV)	Lung Disease	Kidney Problems
Sickle Cell	Stroke	Hepatitis	Osteoporosis	Bleeding Problems	Colitis / Crohn's
Mental Disorders	Poor Circulation	High Blood Pressure	Joint Implants	Thyroid Disease	
Rheumatic Fever	Heart Burn / Reflux	Sexually Transmitted Diseases	High Cholesterol		

Cancer; type _____ Other: _____

Diabetes; What is the name, phone number, and address of the doctor treating you for diabetes?_____

When was your last visit? ____/____/____ What is your average blood sugar reading? _____

12) Do your legs swell? ____Yes ____No

13) Do you have back problems or have had a back injury? ____Yes ____No

14) SURGICAL HISTORY: Please list ALL surgeries you have had in a lifetime.

Procedure	Date	Complications

15) Have you ever been hospitalized other than for surgery? ____Yes ____No Explain_____
_____

16) Have you ever had an injury to the lower extremity? ____Yes ____No Explain_____

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17) SOCIAL HISTORY

Date of last physical Exam: ____/____/___ Occupation:_____

Activities: _____

Level of activity: ____Occasional ____Weekly ____Competitive ____Professional

Do you smoke tobacco? ____Yes ____No **If Yes**: # packs per day? ____ # cigarettes per day? ____

# of years smoking? _____

If No: Did you ever smoke? ____Yes ____No **If Yes:** How long ago did you stop smoking? _____ **Do you smoke vaporized products?** _____Yes _____No What Type:_____

Do you drink **alcohol**? ____Yes ____No

If Yes: How much? ____< 1 per week ____1-2 per week ____1-2 per day ____more than 3 per day

Recreational drug use * Any type of drug use is a personal choice and will in no way adversely affect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer: ____Yes ____No

If Yes: What substance and how often used? _____

18) FAMILY HISTORY *** Please check all that apply**

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Stroke				

19) ALLERGIES: **NONE** **OTHER** _____

Penicillin **Sulfa** **Iodine** **Aspirin** **Anesthetics** **Latex** **Codeine** **Demerol** **Darvocet**

Cortisone **Environmental** **Food** **Eggs** **Insects** **Type of**

Reactions:_____

20) MEDICATIONS: Pharmacy: _____

Medication	Dosage	How Often Taken?	What is it Taken for?

NOTICE OF PRIVACY PRACTICES (HIPAA REGULATIONS)

You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT:

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature:_____ Date:_____/_____/_____