

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age \_\_\_\_\_

### History & Medical Information

1. Explain your foot/ankle problem  Right  Left \_\_\_\_\_  
\_\_\_\_\_

2. When did pain/discomfort begin (date): \_\_\_\_\_  
Describe pain/discomfort:  Burning  Numbness  Sharp  Other \_\_\_\_\_

3. What makes the pain/discomfort better: \_\_\_\_\_

4. Have you had a physical trauma?  No  Yes \_\_\_\_\_

5. Have you had an accident?  No  Yes \_\_\_\_\_

6. Occupation: \_\_\_\_\_ Is your problem work related?  Yes  No

7. Past Medical History:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Lung/Respiratory Disorders	<input type="checkbox"/> Other Arthritis
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Nerve Disorders	<input type="checkbox"/> Stroke
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Neurological Disorders	<input type="checkbox"/> Kidney Disease
		<input type="checkbox"/> Prostate Disorders	<input type="checkbox"/> Other: _____

8. List all medications/herbs/vitamins:  NONE \_\_\_\_\_  
\_\_\_\_\_

9. Allergies: (Describe reaction)  NONE

<input type="checkbox"/> Penicillin _____	<input type="checkbox"/> Aspirin _____
<input type="checkbox"/> Anesthesia _____	<input type="checkbox"/> Shellfish _____
<input type="checkbox"/> Nickel / Metal _____	<input type="checkbox"/> X-ray/Contrast Dye _____
<input type="checkbox"/> Other _____	
<input type="checkbox"/> Sulfa Drugs _____	

In Office Use only:

Varic: Present	Absent	L	R
Edema 1+ 2+ 3+ 4+	Temp	C	W
Nails: Hypertrophic	Mycotic		
CPT: <2.5 sec.	>2.5 sec.		
PT 1 2 3 4 LT	1 2 3 4 RT		
DP 1 2 3 4 LT	1 2 3 4 RT		
Hair: Present	Sparse	Absent	

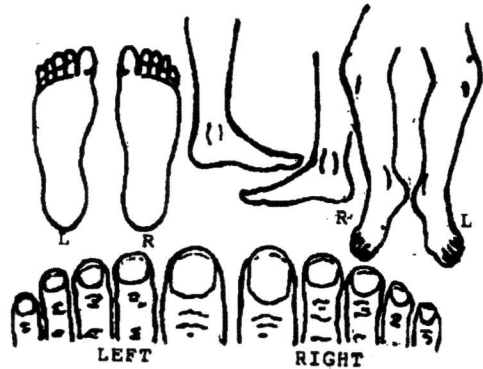
10. Are you currently pregnant?  No  Yes

Neuro: Protective Sensation

11. Surgical History: Have you had surgery?  Yes  No

If yes-describe below:

Surgery / Date: \_\_\_\_\_  
\_\_\_\_\_



12. Social History: (Only check what is pertinent to you)

<input type="checkbox"/> Tobacco Use	<input type="checkbox"/> Alcohol Use
<input type="checkbox"/> Caffeine Use	<input type="checkbox"/> Drug use (recreational, IV)
<input type="checkbox"/> Exercise habits _____	

13. Family History: (List relationship of family member(s) who have had these problems):

<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Mental Illness _____
<input type="checkbox"/> Rheumatology _____	<input type="checkbox"/> Bleeding Disorders _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Other family History: _____		

14. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe size: \_\_\_\_\_

15. Name of Family Physician \_\_\_\_\_ Date last seen by this doctor \_\_\_\_\_