Patient Medical History

What is the reason for your visit today?
_____
When did this problem begin?
_____
Describe anything that may have caused it:
_____
Have you seen another doctor for this problem? ❑Yes ❑No
Describe any previous treatment or home remedies?
_____
_____

Social History

Height: _____ Weight: _____ Shoe Size: _____
List any sports or exercise activities:
_____
Do you wear orthotics or a shoe insert? ❑Yes ❑ No

Do you now or did you ever smoke cigarettes? ❑ Yes ❑ No
Packs/Day: _____#Years: _____
If you have quit smoking, when?_____
Do you drink alcoholic beverages?
❑ None ❑ Occasionally ❑ Weekly #___ ❑ Daily #___
Do you use "recreational" drugs? ❑ Yes ❑ No
List: _____

Surgical History

Have you had any of the following types of surgery?
Orthopedic (e.g. joint repair, fractures) ❑ Yes ❑ No
Heart (e.g. valve, pacemaker, bypass) ❑ Yes ❑ No
Vascular (e.g. vein stripping, angioplasty) ❑ Yes ❑ No
Spinal (e.g. disk repair, fusion) ❑ Yes ❑ No
If 'yes' to any of the above, please describe. *Include year*:
_____
_____
_____

Family History

Has anyone in your *immediate* family been treated for:

	Relation	☑ Deceased
❑ Diabetes		❑
❑ Poor Circulation		❑
❑ Blood Clots		❑
❑ Cancer_____		❑

Allergies

Allergen *(drug, food, etc.)*	**Reaction** *(rash, hives, nausea, etc.)*

Past Medical History

Have you ever been treated **by a doctor** for: *(check all that apply)*

❑ Diabetes - Type I or II ➔Last blood sugar or HbA1c____
❑ Fractures_____
❑ Arthritis_____
❑ Peripheral Vascular Disease
❑ Neuropathy
❑ High Cholesterol
❑ Congestive Heart Failure
❑ Heart Attack or MI
❑ Stroke - CVA or TIA
❑ Anxiety or Depression
❑ Phlebitis or Blood Clots
❑ Chemical or Drug Dependency
❑ GERD or Peptic Ulcer Disease
❑ Osteopenia or Osteoporosis
❑ Lymphedema
❑ Foot or Leg Ulcers
❑ Gout
❑ Liver Problems
❑ Kidney Problems
❑ Cancer_____
❑ High Blood Pressure
❑ Atrial Fibrillation
❑ Fibromyalgia
❑ Seizure Disorders
❑ Glaucoma or Cataracts
❑ Anemia
❑ AIDS / HIV
❑ Asthma
❑ Parkinson's
❑ Other(s)_____

Review of Systems

Please check which of the following symptoms, if any, you are *currently* experiencing:

❑ dramatic weight change
❑ shortness of breath
❑ chest pain or palpitations
❑ nausea or vomiting
❑ constipation
❑ joint pain _____
❑ low back pain
❑ numbness or tingling of toes
❑ confusion or forgetfulness
❑ frequent loss of balance
❑ skin rashes or itch
❑ swelling of feet or ankles
❑ cramps in calf muscles
❑ fever or chills
❑ fainting or dizziness
❑ heartburn or reflux
❑ diarrhea
❑ stomach pain
❑ muscle aches
❑ sciatica (right / left)
❑ tremors or shaking
❑ shuffling or drop foot
❑ dry or cracked skin
❑ bruises easily
❑ blue or purple toes
❑ cold feet and hands

Medications – Prescription and Non-prescription

****include any over-the-counter medications and vitamins*

Medication Name	**Dosage**

I give permission to the doctor to administer and perform such treatments and procedures as may be deemed necessary in the diagnosis and/ or treatment of my feet and/ or ankles.

Patient Signature_____**Date**_____