

Today's Date _____

Mr. Mrs. Miss, Ms. Dr. _____
(circle one) First Name Middle Initial Last Name

Address: _____

_____ City State Zip Code

Telephone: Home _____ Work: _____ Cell _____

Email: _____

Sex: M / F Birth Date: ____/____/____ Age: _____

Please tell us whom to thank for referring you: _____

CHIEF COMPLAINT

Describe your primary foot problem:

How long has it been bothering you? _____

How would you describe the pain? (circle one) Sharp---Dull---Throbbing---Shooting

How severe is it? (circle one) Minimal---Mild---Moderate---Severe

Does anything aggravate the problem? (circle one) No---Yes, what? _____

Does anything make it feel better? (circle one) No ---Yes, what? _____

When does it bother you the most? Standing---Walking---Morning---Night---All the time

(circle all that apply)

Any past foot problems? _____

Shoe Size? _____ Height? _____ Current Weight? _____

What is your occupation? _____

Do you _____ sit at your job _____ stand at your job _____ sit and stand at your job?

Are you required to wear any particular type of work shoe? If yes, what type? _____

REVIEW OF SYSTEMS: Have you had any of the following in the last year?

(Circle all that apply in each category. If none, then circle "None of these")

1. **Constitutional:** Weight loss---Fever--- Night sweats---Chills---Loss of Energy---Abnormal thirst---*None of these*
2. **Eyes:** Glasses or Contacts---Blurry Vision---Itchy Red Eyes--- *None of these*
3. **ENT:** Ear Pain---Hearing Loss---Sinus Problems---Nose Bleeds---Dental Problems---Cold Sores---*None of these*
4. **Cardiovascular:** Chest Pain---Murmur---Blockage of Arteries---Mitral valve disease---Irregular Heart Beat-----*None of these*
5. **Respiratory:** Shortness of Breath---Chronic cough---Painful Breathing---Blood Clot in Lungs---Asthma--- *None of these*
6. **Gastrointestinal:** Heartburn---Frequent Diarrhea---Bloody Stools---Food Intolerance---Nausea---*None of these*
7. **Genital Urinary:** Bladder problems---Frequent Urination---Burning---Painful Urination---Bloody Urine---*None of these*
8. **Musculoskeletal:** Joint Pain---Back Pain---Stiffness---Muscle Weakness---Clots in Leg---*None of these*
9. **Skin:** Significant Rashes---Lesions---Itch---Eczema---Sores--- *None of these*
10. **Neurologic:** Numbness---Seizures---Stroke---Frequent Headaches---Dizziness---Tingling---Memory Loss---Fainting
Tremor---Paralysis---Low Back Pain---Herniated Disc--- *None of these*
11. **Psychiatric:** Excessive Worry---Depression---Thoughts of harming yourself or others---*None of these*
12. **Endocrine:** Diabetes Mellitus---Thyroid Problems---Osteoporosis---Hot Flashes---Hair Loss---*None of these*
13. **Hematologic:** Bleeding---Bruising---Anemia---Painful Nodes---Blood Abnormalities---*None of these*
14. **Allergic/ Immunologic:** Hives---Allergies---*None of these*

MEDICAL HISTORY

Do you have or have you ever been treated for any of the following (check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal bleeding, | <input type="checkbox"/> Gout | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Abnormal Healing | <input type="checkbox"/> Hearing/ Ear disorder | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other Heart Conditions | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis, Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> HIV | <input type="checkbox"/> Spinal/Disc Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine headaches | |
| <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Neurological Problems | |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> None of these |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | |

Patient Name: _____ Date: _____

Name

Location

Telephone

Family/Primary

Physician: _____

Preferred Pharmacy: _____

Are you **allergic** or **sensitive** to any of the following medications?

	YES	NO
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Morphine / Demerol	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin / Advil / Aleve	<input type="checkbox"/>	<input type="checkbox"/>
Novacaine / Lidocaine	<input type="checkbox"/>	<input type="checkbox"/>
Iodine or Shellfish	<input type="checkbox"/>	<input type="checkbox"/>
Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>
Other Medications _____		

What medications are you taking regularly?

Do you have any artificial joints? (circle one) **No** **Yes**, which joint? _____

Have you had any major surgeries? _____

Do any of your family members (mother, father, sister, brother) have or had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Diabetes, who? _____ | <input type="checkbox"/> Bleeding Disorder _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Bunions _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hammertoes _____ |
| <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Circulation Problems _____ |

Do you smoke? _____ No _____ Yes _____ # of packs per day

Have you smoked in the past? _____ No _____ Yes _____ # of packs per day

Do you drink alcoholic beverages? _____ No _____ Yes If yes, how much?
_____ 1-2 drinks per week _____ 1-2 drinks per day _____ More than 2 drinks per day

Do you use drugs? _____ No _____ Yes

X _____
Signature of Person filling out this form

Relationship to Patient: _____
(if applicable)

I have reviewed the above information _____ Date: _____
(Physician's signature)