

## MEDICAL HISTORY

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath      |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Ear Problems       | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> Sinus Problems           |
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> *Special Diet            |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Eye Problems       | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Nervous Problems    | <input type="checkbox"/> Swelling in Ankles, Feet |
| <input type="checkbox"/> Back Problems       | <input type="checkbox"/> Foot or Leg Cramps | <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Swollen Neck Glands      |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Gout               | <input type="checkbox"/> Psychiatric Care    | <input type="checkbox"/> Tired Feet               |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcers                   |
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Rash                | <input type="checkbox"/> Weight Loss, unexplained |
| <input type="checkbox"/> Chronic Diarrhea    | <input type="checkbox"/> Hemophilia         | <input type="checkbox"/> Respiratory disease |   |

## PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

Have you ever been to a podiatrist before?     Yes     No

If you answered yes, please list below.

Name \_\_\_\_\_

Last Visit Date \_\_\_\_\_

Please indicate which foot problems you now have or have had in the past.

- |   |   |
|---|---|
| <input type="checkbox"/> Ankle Pain         | <input type="checkbox"/> Ingrown Toenails     |
| <input type="checkbox"/> Athlete's Foot     | <input type="checkbox"/> Plantar Warts        |
| <input type="checkbox"/> Corns & Calluses   | <input type="checkbox"/> Swelling in the Feet |
| <input type="checkbox"/> Cramps or Numbness | <input type="checkbox"/> Tired Feet           |
| <input type="checkbox"/> Flat Feet          |   |
| <input type="checkbox"/> Heel Pain          |   |

### MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins \_\_\_\_\_

Pharmacy Name(s) \_\_\_\_\_

Pharmacy Phone(s) \_\_\_\_\_

Do you take oral contraceptives?     Yes     No

### ALLERGIES

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Adhesive/Tape     | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Seafoods   |
| <input type="checkbox"/> Codeine           | <input type="checkbox"/> Sulfa      |
| <input type="checkbox"/> Demerol           | <input type="checkbox"/> Novocaine  |
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Iodine     |
| <input type="checkbox"/> Other _____       |                                     |

## CONSENT

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

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_