

Patient Name: _____ Date: _____

History & Medical Information

1. **Explain your foot/ankle problem** Right Left _____
2. **Describe the pain/discomfort:** Burning Numbness Sharp Other _____
3. **When did the pain/discomfort begin?** _____
4. **What makes the pain/discomfort better:** _____
5. **What makes the pain/discomfort worst:** _____
6. **List all medications/herbs/vitamins:** NONE _____
7. **Allergies:** (Describe reaction) NONE
- Penicillin _____ Aspirin _____ Narcotic Agent / Codeine _____
- Anesthesia _____ Shellfish _____ Sulfa Drugs _____
- Nickel / Metal _____ Radiographic Contrast Dye _____
- Other _____

8. Past Medical and Family History

Condition	Self	Family	Condition	Self	Family
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anesthetic Reaction	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Nails Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Nerve Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Avg Glucose _____	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Foot Problem(s)	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intest Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Injury Trauma - Major	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>

9. **Surgical History:** Have you had surgery? Yes—if yes, describe below No
- Surgery / Date: _____

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

- Tobacco Use Alcohol Use Exercise habits _____
- Caffeine Use Drug use (recreational, IV)

11. **Occupation:** _____ **Is your problem work related?** Yes No

12. **Are you currently pregnant?** _____

13. **Height:** _____ **Weight:** _____ **Shoe Size:** _____

For office use: B/P _____ Pulse _____ Resp. _____ Temp. _____

PATIENT NAME: _____

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced**.

Constitutional			
<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Sweats	<input type="checkbox"/> Weight Change
Head, Eyes, Ears, Nose and Throat			
<input type="checkbox"/> Wear Contact Lenses	<input type="checkbox"/> Dentures	<input type="checkbox"/> Wearing Eyeglasses	
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Cataract	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Sore Throat	
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Problems with eyesight	<input type="checkbox"/> Ringing in the Ears	
Cardiovascular			
<input type="checkbox"/> Chest Pain / Discomfort	<input type="checkbox"/> Cardiovascular Symptom	<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> Swelling lower extremity	<input type="checkbox"/> Leg Pain with Exercise	<input type="checkbox"/> Palpitations	
Hematologic/Lymphatic			
<input type="checkbox"/> Bleeding Problem	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Lymphoma	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Skin Lump - Location		
Respiratory			
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Previous Pulmonary Disease	
<input type="checkbox"/> Exposure to TB	<input type="checkbox"/> Cough	<input type="checkbox"/> Pulmonary Symptoms	
Gastrointestinal			
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Decrease in Appetite	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Constipation	
Endocrine			
<input type="checkbox"/> Often Thirsty	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Urinary Symptoms	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Prior Kidney Disease	
Musculoskeletal			
<input type="checkbox"/> Musculoskeletal symptoms	<input type="checkbox"/> Feeling weak	<input type="checkbox"/> Joint Pain, Arthralgia	
<input type="checkbox"/> Weakness of limbs	<input type="checkbox"/> Prior Fracture		
Nervous System			
<input type="checkbox"/> Ataxia	<input type="checkbox"/> Speech Difficulties	<input type="checkbox"/> Headache	
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Confusion/ Disorientation	<input type="checkbox"/> Fainting	
<input type="checkbox"/> Convulsions			
Skin			
<input type="checkbox"/> Rash	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Lesions	<input type="checkbox"/> Sun Sensitivity
<input type="checkbox"/> Color Change	<input type="checkbox"/> Slow Healing	<input type="checkbox"/> Infections	<input type="checkbox"/> Cracking
<input type="checkbox"/> Eczema (Pruritus)	<input type="checkbox"/> Growth	<input type="checkbox"/> Hair Loss	
Allergic, Immunologic History			
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Lupus	<input type="checkbox"/> Collagen Vascular
Psychiatric			
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tension	<input type="checkbox"/> Depression	