Podiatric and Medical History

Date: _____

Name: _____

Weight_____ Height_____ Shoe Size _____ Shoe Style (Boot, Heel, Athletic, Casual, Dress, Sandals, flip-flops, backless)

Chief Complaint: (What brings you into the office today? Please provide detailed information)

_____

Location: (Where is your pain?) _____

Please indicate the **severity** of the pain or discomfort. (Circle) None Mild Moderate Strong Severe

When did this initially **start**? _____ Days Weeks Months Years **AGO**

How would you **describe** the discomfort? (Circle those that apply)
Sharp Shooting Throbbing Tingling Numb Burning Itching Aching Tender Dull

Have you had any treatment done for this condition? YES NO

If yes, what kind?_____

What **aggravates** the condition? (Circle all that apply) Shoes Walking No Walking Activities

Other _____

Have you ever been treated for any of the following: (please **circle** those that apply)

Corns/Calluses Warts Rash Leg or Foot Ulcers Fungus Nails Athlete's Foot Broken foot bones Neuroma Ingrown Nails
Hammertoes Broken Ankle Foot numbness Cramps in legs/feet Bunions Ankle sprain Lower Back Pai Arch Pain
Gait (walking) problems Knee Pain Childhood Problems In-toeing Toe Walking Flat Feet High Arches
Other: _____

Did you previously or do you now wear?:

Shoe Insoles? _____ If yes, are you still using them? _____ Did they help? _____

Orthotics? _____ If yes, are you still using them? _____ Did they help? _____

Percent of waking hours spent on your feet? 10% 20% 40% 60% 80% 100%

List the sports or activities you are involved in: (Walking, Running, Weights, Cycling, Pilates, Aerobics, Curves, Treadmill)

Social History:

Do you **smoke now?** Yes or No If yes how many packs a day? _____ For how many years? _____
Did you ever **smoke**? Yes or No If yes how many packs a day? _____ For how many years? _____
If you quit, when did you do so? _____

Alcoholic beverages? (Circle) None Rarely Moderately Daily (# per day _____) Quit

Recreational Drugs? (Circle) None Rarely Moderately Daily Quit

PATIENT REVIEW OF SYSTEMS *Please check all the symptoms you are currently experiencing*

CONSTITUTIONAL
- ❑ Fever
- ❑ Fatigue/Weakness
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ OTHER:

EYES
- ❑ Blurred Vision
  Failing Vision
- ❑ Vision Loss
- ❑ Eye Pain
- ❑ OTHER:

ENT
- ❑ Ear Discharge
- ❑ Hearing Loss
- ❑ Nosebleeds
- ❑ OTHER:

CHEST
- ❑ Swelling
- ❑ Masses _____
  Pain
- ❑ OTHER:

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Heart Defects
- ❑ Palpitations
- ❑ Murmurs _____

RESPIRATORY
- ❑ Difficulty Breathing
- ❑ Chronic Coughing
- ❑ Pneumonia
- ❑ Shortness of Breath
- ❑ History of TB
  TB Exposure
- ❑ OTHER: _____

GASTROINTESTINAL
- ❑ Appetite Loss
- ❑ Nausea (persistent)
- ❑ Vomiting
- ❑ Chronic Diarrhea
- ❑ Constipation
- ❑ Abdominal Pain
- ❑ GI Bleed
- ❑ Ulcers/Reflux/GERD
  Blood in Stool
- ❑ Hepatitis
- ❑ OTHER:

GENITOURINARY
- ❑ Difficult Urination
  Frequent Urination (PM)
- ❑ Leakage of Urine
- ❑ Passing Stones
- ❑ Pregnancy
- ❑ Other _____

MUSCULOSKELETAL
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Muscle Cramps
- ❑ Muscle Weakness _____
- ❑ Numbness
- ❑ Stiffness
  Arthritis
- ❑ Ankle Swelling
- ❑ Disturbance in walking
- ❑ Tingling Sensation
- ❑ OTHER:

NEUROLOGICAL
- ❑ Memory Loss
- ❑ Seizures
- ❑ Weakness
- ❑ Dizzy Spells
- ❑ Severe Headaches
- ❑ Difficulty Walking _____
  Stroke/TIA
- ❑ OTHER:

PSYCHIATRIC
- ❑ Depression
- ❑ Anxiety _____
- ❑ Memory Loss
- ❑ OTHER: _____

ENDOCRINE
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Diabetes
- ❑ Thyroid Trouble
- ❑ OTHER: _____

VASCULAR/IMMUNO
- ❑ Abnormal Bruising
  Bleeding Disorders
- ❑ HIV
- ❑ OTHER:

ALLERGY
- ❑ Latex Allergy
- ❑ Drug Allergies
- ❑ Recurrent Infections
- ❑ Adhesive bandages
- ❑ Anesthesia Complications
- ❑ Nickel (metal)
- ❑ Stainless Steel
- ❑ OTHER: _____

SKIN
- ❑ Skin Rash
  Itching
- ❑ Suspicious Lesions
- ❑ OTHER: _____

Surgical Procedures (You Have Had Performed and approx Date performed):

_____

_____

_____

Hospitalizations (Other than for Surgeries): _____

Family History:

NO PAST MEDICAL HISTORY

Disorder	**Who**			
❑ Alcohol Liver Disease	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Bleeding Disorder	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Colon Polyps	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Diabetes 12	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ GERD	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Heart Disease	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Stroke	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Anesthetic Complic	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Cancer	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
Type: _____	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
Type: _____	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
Type: _____	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent

Hobbies: _____

Medications: (please provide a list to the receptionist if needed)

NAME	Reason for taking	Dose

Pharmacy: _____Location: _____ Phone: _____

Allergies:	**YES**	**NO**		**YES**	**NO**
Penicillin	_____	_____	Latex	_____	_____
Morphine	_____	_____	Codeine	_____	_____
Novocaine	_____	_____	Other Anesthetics	_____	_____
Aspirin	_____	_____	Advil, Aleve, Motrin	_____	_____
Sulfa Drugs	_____	_____	Adhesive Tape	_____	_____
Shrimp, Iodine, Merthiolate	_____	_____			

Others: _____
_____

CONSENT TO TREATMENT

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

Patient Signature_____ Date _____

Guardian Signature _____ Date _____