

PATIENT HISTORY REVIEW

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability. Thank you.

Patient Name _____ Birth date _____

How may we help your feet? CHIEF COMPLAINT _____

How long have you had this problem? _____ Does anyone in your family have a similar problem? _____

What does it feel like when it hurts (circle): numbness tingling burning sharp aching pressure

Does the pain radiate or move? _____ other: _____ How do you make it feel better? _____

List other treatments/consultations (who, when) _____

Is your condition an injury, if so how was injury incurred? _____

Is this a work related injury? _____ If yes, has your employer been notified? _____

MEDICAL REVIEW

Mark an "X" if you have ever had the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Blood or Plasma Transfusions |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Polio | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hives or Eczema | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Back trouble | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Auto-immune disease (type _____) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hepatitis (__A, __B, __C, __) |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Family history of problems with anesthesia |
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Slow healing |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Cancer (type _____) |
| | | <input type="checkbox"/> Current chemotherapy |

SYSTEMS REVIEW

Mark an "X" if you have ever had any of the following:

CONSTITUTIONAL SYMPTOMS

- Good general health lately
- recent weight change
- fever
- fatigue
- headaches

MUSCULOSKELETAL

- joint stiffness or swelling
- joint pain
- weakness of muscles or joints
- muscle pain or cramps
- joint replacements (name _____)
- cold extremities
- difficulty in walking

NEUROLOGICAL

- frequent or recurring headaches
- light headed or dizzy
- convulsions or seizures
- numbness or tingling sensations
- tremors
- paralysis

PODIATRIC

- numbness/tingling of feet
- problems with cold feet
- foot ulcers
- previous injuries/fractures

CARDIOVASCULAR

- heart trouble
- chest pain or angina pectoris
- palpitation
- shortness of breath w/ walking or lying flat
- swelling of hands or feet
- heart valve replacement
- vascular grafts
- high blood pressure

ENDOCRINE

- diabetes(type _____ how long _____)
- glandular or hormone problems
- excessive thirst or urination
- heat or cold intolerance
- skin becoming drier
- change in hat or glove size

PSYCHIATRIC

- ___ memory loss or confusion
- ___ nervousness
- ___ depression
- ___ insomnia

INTEGUMENTARY (SKIN)

- ___ rash or itching
- ___ change in skin color
- ___ change in hair or nails
- ___ varicose veins

ALLERGIC/IMMUNOLOGIC

History of skin or other adverse reaction to (specify):

- ___ Penicillin or other antibiotics
- ___ Morphine, Demerol or other narcotics
- ___ Novocain or other anesthetics
- ___ Aspirin or other pain remedies
- ___ Tetanus antitoxin or other serums
- ___ Iodine, Merthiolate or other antiseptic

HEMATOLOGIC/LYMPHATIC

- ___ slow to heal after cuts
- ___ bleeding or bruising tendency
- ___ anemia
- ___ phlebitis
- ___ past transfusion
- ___ enlarged glands

Known food allergies (list) _____

Environmental allergies _____

Other drugs/medications _____

Do you take:

Insulin (or other diabetic medications) _____ Blood thinner (name) _____

Name of diabetic medicines _____ Diuretics (water pills) _____

Heart medication (name) _____ List all other medication, supplements, vitamins:

Do you:

___ Drink alcohol ___ # of drinks per day

___ Smoke ___ # of pack per day

___ Use recreational drugs (cocaine, marijuana, IV drugs, etc.)

Type of drug(s) _____ How often? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need.

Signature of patient, parent or guardian

Date

Doctor's review