

(Patient's Name)

(Today's Date)

What and where is your primary foot or ankle problem? \_\_\_\_\_

When did you first notice the problem? \_\_\_\_\_

Have you ever had treatment for this problem, and by whom? \_\_\_\_\_

What is your Weight? \_\_\_\_\_ Height? \_\_\_\_\_ Shoe Size? \_\_\_\_\_

Primary Physician: Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Physician Seen (check one): As needed: \_\_\_\_\_ Regularly for treatment: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Have you ever or are you currently being treated for any of the following (please check box if answer is YES):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Arthritis     |
| <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> Asthma/short of Breath | <input type="checkbox"/> Gout          |
| <input type="checkbox"/> Numbness of Legs/Feet   | <input type="checkbox"/> Poor Circulation       | <input type="checkbox"/> Strokes       |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Phlebitis     |
| <input type="checkbox"/> Bleeding Disorders      | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Implants      |
| <input type="checkbox"/> Swelling of Ankle/Feet  | <input type="checkbox"/> Varicose Veins         | <input type="checkbox"/> Keloid Scars  |
| <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Thyroid Problems       |  |

Other: \_\_\_\_\_

Please list the names and dosages of any medications which you are now taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am NOT currently taking any medications

Allergies: Are you allergic or sensitive to any medications/agents? Please list the agent and reaction to the agent: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Previous Hospitalization OR Surgeries: Please state nature of the problem or surgery and the year it occurred. Any complications? \_\_\_\_\_

\_\_\_\_\_

Patient Name \_\_\_\_\_

Childhood Illnesses: Have you ever had any of the following? (check box if YES):

- Chicken Pox       Scarlet Fever       Cystic Fibrosis       Cerebral Palsy  
 Mumps               Whooping Cough       Multiple Sclerosis       Epilepsy  
 Measles               Rheumatic Fever       Polio  
 Any Neurological Diseases

**Social History: Please check appropriate column to describe use of the following:**

|                | Describe agent | Rarely | Occasionally | Daily |
|----------------|----------------|--------|--------------|-------|
| Tranquilizers  |                |        |              |       |
| Sleeping Pills |                |        |              |       |
| Coffee or Tea  |                |        |              |       |
| Alcohol        |                |        |              |       |
| Aspirin        |                |        |              |       |
| Tobacco        |                |        |              |       |

**Family History: IF LIVING IF DECEASED**

|                   | Age | Health |  | Age | Cause of Death |
|-------------------|-----|--------|--|-----|----------------|
| Father            |     |        |  |     |                |
| Mother            |     |        |  |     |                |
| Brothers /Sisters |     |        |  |     |                |
|                   |     |        |  |     |                |
| Sons/Daughters    |     |        |  |     |                |
|                   |     |        |  |     |                |

**Has any blood relative ever had: (please check NO or YES and list who)**

| NO | ILLNESS                         | YES | If YES list who (father, mother etc) |
|----|---------------------------------|-----|--------------------------------------|
|    | Cancer                          |     |                                      |
|    | Tuberculosis                    |     |                                      |
|    | Diabetes                        |     |                                      |
|    | Heart Disease                   |     |                                      |
|    | Rheumatoid Arthritis            |     |                                      |
|    | Gout                            |     |                                      |
|    | High Blood Pressure             |     |                                      |
|    | Foot Problems (ie bunions, etc) |     |                                      |
|    | Kidney Disease                  |     |                                      |
|    | Stroke                          |     |                                      |
|    | Bleeding Tendencies             |     |                                      |
|    | Alcoholism                      |     |                                      |
|    | Hepatitis/Liver Disease         |     |                                      |
|    | Thyroid Disease                 |     |                                      |
|    | Any Neurological Disease        |     |                                      |