

Patient History

Patient Name: _____

Today's Date: _____ Chart Number: _____

Ingrown Toenail(s): Infected? Yes No

If Yes, are you on an antibiotic? Yes No If Yes, Date Started: _____

Is the foot pain due to an injury? Yes No If Yes, where did the injury occur? Home Work

Circle your level of pain (10 being the highest level of pain): 1 2 3 4 5 6 7 8 9 10

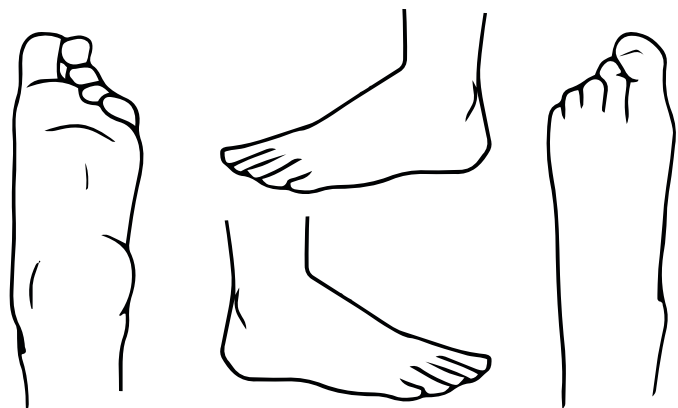
Describe Type of Pain:

Aching Pain Sharp Pain Burning Pain Tingling Pain Numbness

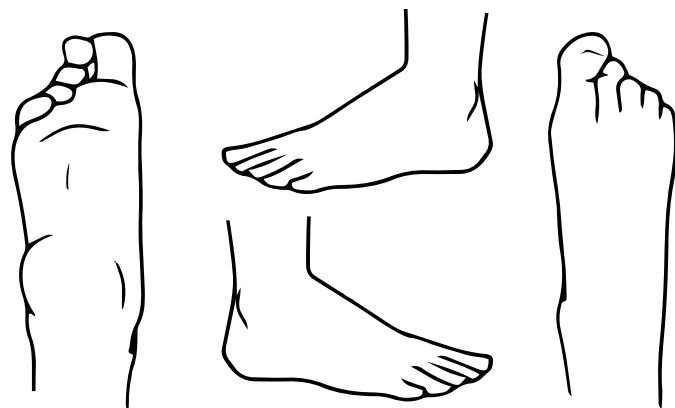
Other: _____

Where does it hurt? (Circle and describe the painful area)

Left Foot



Right Foot



How long have you had pain or this condition? _____

Have you been treated for or have you had surgery for this pain or condition? Yes No

MEDICAL ALERTS (PLEASE CHECK ALL THAT APPLY)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Aspirin (Taken daily) | <input type="checkbox"/> Plavix®/Clopidogrel | <input type="checkbox"/> Aggrenox®/Dipyridamole | <input type="checkbox"/> Naproxen/Naprosyn® |
| <input type="checkbox"/> Aleve® | <input type="checkbox"/> Celebrex® | <input type="checkbox"/> Voltaren®/Diclofenac | <input type="checkbox"/> Lovenox® Enoxaparin Injection |
| <input type="checkbox"/> Coumadin®/Warfarin | <input type="checkbox"/> Pradaxa®/Dabigatran | <input type="checkbox"/> Sulindac | <input type="checkbox"/> Fish Oil/OMEGA 4/Krill Oil |
| <input type="checkbox"/> Neurontin® | <input type="checkbox"/> Mobic®/Meloxicam | <input type="checkbox"/> Ibuprofen/Motrin®/Advil® | <input type="checkbox"/> Indocin® |
| <input type="checkbox"/> Lodine® | <input type="checkbox"/> Vitamin E | <input type="checkbox"/> Black Cohosh | <input type="checkbox"/> Hormone Replacement |

Birth Control: Pill Patch Injection

History of Tobacco Use: Never Quit Smokes _____ packs of cigarettes a day for _____ years
 Cigars _____/day Pipe

PATIENT AND FAMILY MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

	SELF	FATHER	MOTHER	SIBLINGS		SELF	FATHER	MOTHER	SIBLINGS
Blood Clot/DVT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heel Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bunions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MRSA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nail Fungus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AFIB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vericose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MVP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abscess/Cellulitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toe Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hammer Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ingrown Toenail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STAPH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Feet/Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypotension (Low Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List history of other medical conditions here: _____

SURGICAL PROCEDURES (PLEASE CHECK ALL THAT APPLY)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Bunion | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Tonsils/Adenoids | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Cyst Removed |
| <input type="checkbox"/> Morton's Neuroma | <input type="checkbox"/> Appendix | <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Lymph Glands Removed |
| <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Eyes/Cataracts | <input type="checkbox"/> Achilles Tendon |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Brain | <input type="checkbox"/> Joint Replacement in Foot | |
| <input type="checkbox"/> Amputation: _____ | | <input type="checkbox"/> Other Foot Surgery: _____ | |
| <input type="checkbox"/> Cancer: _____ | | | |

Implants: Pacemaker ICD/Defibrillator Heart Stents Insulin Pump

Screws, Pins, Rods, Clips in: Feet/Toes Knees Hips Spine Neck Hands/Fingers Wrist/Arms Brain
 Other Stents: _____ Other Implants: _____ Copy Implant Card

ALLERGIES (PLEASE CHECK ALL THAT APPLY)

- | | | | | | |
|-------------------------------------|----------------------------------|--------------------------------------|---|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Sutures | <input type="checkbox"/> Metals | <input type="checkbox"/> Iodine on Skin | <input type="checkbox"/> Morphine | <input type="checkbox"/> Bactrim® |
| <input type="checkbox"/> Iodine Dye | <input type="checkbox"/> Tape | <input type="checkbox"/> Latex | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Demerol® | <input type="checkbox"/> Levaquin® |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Keflex® | <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Cipro® | <input type="checkbox"/> Codeine | <input type="checkbox"/> Augmentin™ |

List others here: _____

PRESCRIPTIONS, INCLUDING DOSAGE (COPY FROM BOTTLES FOR ACCURACY)

MEDICATION NAME	DOSAGE

- CPAP Nebulizer Oxygen Insulin Pump

Are you taking chemotherapy or have you recently completed chemotherapy? Yes No

Are you taking an antibiotic? Yes No When did you start: _____

VITAMINS, HERBS, AND SUPPLEMENTS (PLEASE CHECK ALL THAT APPLY)

- | | | |
|---|--|--|
| <input type="checkbox"/> Multi-Vitamin Only | <input type="checkbox"/> Vitamin B Complex | <input type="checkbox"/> Vitamin D + Calcium Complex |
| <input type="checkbox"/> Vitamin C _____ units | <input type="checkbox"/> Biotin B6 _____ units | <input type="checkbox"/> Magnesium _____ units |
| <input type="checkbox"/> Potassium _____ units | <input type="checkbox"/> Calcium _____ units | <input type="checkbox"/> Vitamin D _____ units |
| <input type="checkbox"/> Vitamin E _____ units | <input type="checkbox"/> Vitamin B12 _____ units | <input type="checkbox"/> Folic Acid-B9 _____ units |
| <input type="checkbox"/> Niacine B3 _____ units | <input type="checkbox"/> Vitamin K _____ units | <input type="checkbox"/> Glucosamine-Chondroitin |
| <input type="checkbox"/> 5-HTP | <input type="checkbox"/> St. John's Wort | <input type="checkbox"/> Red/Brown Rice Yeast |

List others here: _____