



**Please Print**

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

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Pharmacy Name and Address \_\_\_\_\_

**Chief Complaint** (*Nature of your foot pain or problem*) \_\_\_\_\_

**Location on foot or leg:**

*Check all that apply*

☐ Forefoot/Toes

☐ Middle Foot

☐ Back Part of Foot

☐ Ankle

☐ Top

☐ Bottom

☐ Outer Side

☐ Inner Side

How long has this bothered you? \_\_\_\_\_

How did this begin? \_\_\_\_\_

What course has it taken? \_\_\_\_\_

What aggravates it? \_\_\_\_\_

What makes it feel better? \_\_\_\_\_

What have you done to relive the condition? \_\_\_\_\_

*(If you have seen another doctor to relieve the pain, please give his/her name)* \_\_\_\_\_

**Please list the prescriptions that you take:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are you using any over the counter medications?** \_\_\_\_\_

**If so, which ones (names)?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***Please turn this paper over and complete the questions on the back***

**General Health:** *If you have had or have any of the following, check all that apply:*

- |                                         |                                          |                                                           |
|-----------------------------------------|------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Hip problems   | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Pain, cramps, swelling, tingling |
| <input type="checkbox"/> Ankle problems | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Burning or numbness in feet      |
| <input type="checkbox"/> Shingles       | <input type="checkbox"/> Bruise easily   | <input type="checkbox"/> Burning or numbness in legs      |
| <input type="checkbox"/> Skin problems  | <input type="checkbox"/> Neck pain       | <input type="checkbox"/> HIV                              |
| <input type="checkbox"/> Bone fracture  | <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Shortness of breath              |

Can you take aspirin? \_\_\_\_\_

Have you had a local anesthetic (*such as dental work*)? \_\_\_\_\_

Did you have any problems with it? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink? \_\_\_\_\_ How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Past surgeries or hospitalizations: \_\_\_\_\_

\_\_\_\_\_

**Allergies**

Are you allergic or sensitive to:

- |                                        |                                   |                                      |                                  |
|----------------------------------------|-----------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Penicillin    | <input type="checkbox"/> Novocain | <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Iodine   | <input type="checkbox"/> Metal       | <input type="checkbox"/> Sulfa   |

☐ Drugs: \_\_\_\_\_

☐ I am not allergic to anything that I know of.

**Family Health**

Have you or any of your family members ever had any of the following (*please check all that apply*)

- | You                      | Family                                       | You                      | Family                                  |
|--------------------------|----------------------------------------------|--------------------------|-----------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy       |
| <input type="checkbox"/> | <input type="checkbox"/> Heart trouble       | <input type="checkbox"/> | <input type="checkbox"/> Nerve disease  |
| <input type="checkbox"/> | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> Muscle disease |
| <input type="checkbox"/> | <input type="checkbox"/> Bleeding problems   | <input type="checkbox"/> | <input type="checkbox"/> Bone disease   |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney trouble      | <input type="checkbox"/> | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> | <input type="checkbox"/> Liver problems      | <input type="checkbox"/> | <input type="checkbox"/> Arthritis      |
| <input type="checkbox"/> | <input type="checkbox"/> Anemia              | <input type="checkbox"/> | <input type="checkbox"/> Cancer         |
| <input type="checkbox"/> | <input type="checkbox"/> Lung disease        | <input type="checkbox"/> | <input type="checkbox"/> Asthma         |
| <input type="checkbox"/> | <input type="checkbox"/> Blood disease       | <input type="checkbox"/> | <input type="checkbox"/> Gout           |

**I certify that the above information is accurate and true to the best of my knowledge.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_