Patient Name: ______________________________ **Date:** _______________

Referring Physician Name and Address: ____

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left ____
   ____
2. **When did pain/discomfort begin (date):** ____
   Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other ____________________
3. **What makes the pain/discomfort better:** ____
4. **Have you had a physical trauma?** ☐ No ☐ Yes ____
5. **Have you had an accident?** ☐ No ☐ Yes ____
6. **Occupation:** ______________________________ **Is your problem work related?** ☐ Yes ☐ No
7. **Past Medical History:**
   ☐ Anemia
   ☐ Bleeding Disorders
   ☐ Cancer ____________
   ☐ Diabetes
   ☐ Epilepsy
   ☐ Gout
   ☐ Heart failure
   ☐ Hepatitis
   ☐ High Cholesterol
   ☐ HIV / AIDS
   ☐ High Blood Pressure
   ☐ Kidney Disease
   ☐ Lung/Respiratory Disorders
   ☐ Mitral Valve Prolapse
   ☐ Nerve Disorders
   ☐ Neurological Disorders
   ☐ Prostate Disorders
   ☐ Osteoarthritis
   ☐ Other Arthritis
   ☐ Rheumatic Fever
   ☐ Stroke
   ☐ Thyroid Disorders
   ☐ Other: ____________
8. **List all medications/herbs/vitamins:** ☐ **NONE** ____
   ____
9. **Allergies:** (Describe reaction) ☐ **NONE**
   ☐ Penicillin ____________________
   ☐ Anesthesia ____________________
   ☐ Nickel / Metal ____________________
   ☐ Other ____
   ☐ Aspirin ____________________
   ☐ Shellfish ____________________
   ☐ Radiographic Contrast Dye ____________________
   ☐ Narcotic Agent / Codeine ____________________
   ☐ Sulfa Drugs ____________________
10. **Are you currently pregnant?** ☐ No ☐ Yes ____
11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No
    Surgery / Date: ____
    ____
12. **Social History:** (Only check what is pertinent to you)
    ☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits____________________________
    ☐ Caffeine Use ☐ Drug use (recreational, IV)
13. **Family History: (List relationship of family member(s) who have had these problems):**
    ☐ Diabetes____________________
    ☐ Hypertension ____________________
    ☐ Rheumatology ____________________
    ☐ Heart Disease ____________________
    ☐ Stroke ____________________
    ☐ Bleeding Disorders ____________________
    ☐ Kidney Disease ____________________
    ☐ Mental Illness ____________________
    ☐ Cancer ____________________
    ☐ Other family History: ____
14. **Shoe size:** ______________

Patient Name: ______________________ Date: ____________

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change

Head, Eyes, Ears, Nose and Throat		
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses
☐ Double Vision	☐ Cataract	☐ Dizziness
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears
Cardiovascular		
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations
Hematologic/Lymphatic		
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma
☐ Anemia	☐ Skin Lump - Location	
Respiratory		
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms
Gastrointestinal		
☐ Nausea	☐ Vomiting	☐ Diarrhea
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation
Endocrine		
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease
Musculoskeletal		
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Join Pain, Arthralgia
☐ Weakness of limbs	☐ Prior Fracture	
Nervous System		
☐ Ataxia	☐ Speech Difficulties	☐ Headache
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting
☐ Convulsions		

Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	