

2 PATIENT MEDICAL HISTORY - OVERVIEW

What is your foot/ankle problem? _____

 When did problem begin? Date: _____
 Describe any accident/event: _____

 Is this problem work related? Yes No
 First visit to a Doctor for this problem? Yes No
 Previous x-rays? Yes No If Yes, Date: _____
 Where are they now? _____
 Describe any previous treatment or home remedies?

Have you been treated for:

| | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Intoeing | <input type="checkbox"/> Heel pain |
| <input type="checkbox"/> Broken foot bone(s) | <input type="checkbox"/> Callouses | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Neuroma | <input type="checkbox"/> Corns |
| <input type="checkbox"/> Ankle injury | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Arch pain |
| <input type="checkbox"/> High arch feet | <input type="checkbox"/> Bunions | <input type="checkbox"/> Flat feet |
| <input type="checkbox"/> Ingrown nails | <input type="checkbox"/> Childhood foot problems | |

Do you have or have you ever been treated for:

| | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> HIV | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Apnea* |

*Do you use a CPAP machine? Yes No
 Are you slow to heal after cuts? Yes No
 Any abnormal bruising or bleeding? Yes No
 Any pain in calves or buttocks when walking? Yes No
 Is the pain relieved by rest? Yes No
 Do your feet hurt at night? Yes No
 Currently taking any prescription medications? Yes No
 List: _____

Height: _____ Weight: _____ Shoe Size: _____
 How much are you on your feet at work?
 20% 40% 60% 80% 100%
 List any sports/activities: _____

 Are you taking nutritional or dietary supliments (e.g. Ginkgo biloba, Ginseng, Echinacea)? Yes No
 List _____

Allergies to injection, oral or topical administration of:

| | |
|---|--|
| Penicillin or other antibiotics? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Narcotics?(Morphine, Codeine, Demerol...) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Local anesthetics? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Pain remedies? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Adhesive tape? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Any other drug, medication or treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know |

If "yes" to any of the above, please explain: _____

Do you smoke cigarettes? Yes No Packs/Day: ____ Years: ____
 Did you ever smoke? Yes No Packs/Day: ____ Years: ____
 Do you drink alcoholic beverages?
 None Rarely Moderately Daily Quit
 Do you use "recreational" drugs?
 None Rarely Moderately Daily Quit
 List _____

Have you had a serious illness? Yes No
 Have you been hospitalized or under lengthy medical care? Yes No
 Have you had any surgery? Yes No
 Do you have any implants? Yes No
 Orthopedic (e.g. knee, hip, etc.) Yes No
 Cardiac (e.g. valve, pacemaker, graft, etc.) Yes No
 Cosmetic (e.g. breast, facial, etc.) Yes No
 If "yes" to any of the above, please explain: _____

3 PATIENT PHYSICIANS

Did your Family Physician (PCP) or other Specialist refer you? Yes No

Family Physician: _____
 Date last seen: _____ Phone: () _____
 City: _____ State: _____ Zip: _____

Specialist Dr: _____ Specialty: _____
 Date last seen: _____ Phone: () _____
 City: _____ State: _____ Zip: _____

Are you here for a consultation? Yes No
 Are you here for a surgical evaluation? Yes No

Are you here for a 2nd opinion on surgery? Yes No
 Did you independently come for an opinion? Yes No

4 FAMILY HISTORY

Has any blood relative had:

If "Yes," please indicate who

| | | |
|----------------------|--|-------|
| Tuberculosis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Cancer or tumor? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| High blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Heart trouble? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Birth abnormalities? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Arthritis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Stroke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Foot problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |