Patient Name: _____ **Date:** _____

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left _____

_____

2. **Describe the pain/discomfort:** ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____
3. **When did the pain/discomfort begin?** _____
4. **What makes the pain/discomfort better:** _____
5. **What makes the pain/discomfort worst:** _____
6. **List all medications/herbs/vitamins:** ☐ **NONE** _____

_____

7. **Allergies:** (Describe reaction) ☐ **NONE**

☐ Penicillin _____ ☐ Aspirin _____ ☐ Narcotic Agent / Codeine _____
☐ Anesthesia _____ ☐ Shellfish _____ ☐ Sulfa Drugs _____
☐ Nickel / Metal _____ ☐ Radiographic Contrast Dye _____
☐ Other _____

8. **Past Medical and Family History**

Condition	**Self**	**Family**	**Relation**	**Condition**	**Self**	**Family**	
Anemia	☐	☐	_____	Kidney Disease	☐	☐	_____
Anesthetic Reaction	☐	☐	_____	Liver Disease	☐	☐	_____
Arthritis	☐	☐	_____	Mental Retardation	☐	☐	_____
Asthma	☐	☐	_____	Mitral Valve Prolapse	☐	☐	_____
Bleeding Disorders	☐	☐	_____	Multiple Sclerosis	☐	☐	_____
Cancer	☐	☐	_____	Nails Disorders	☐	☐	_____
Circulation Problems	☐	☐	_____	Nerve Disorders	☐	☐	_____
Diabetes,Avg Glucose____	☐	☐	_____	Obesity	☐	☐	_____
Epilepsy	☐	☐	_____	Phlebitis	☐	☐	_____
Foot Problem(s)	☐	☐	_____	Pulmonary Disease	☐	☐	_____
Gout	☐	☐	_____	Rheumatic Fever	☐	☐	_____
Heart Disease	☐	☐	_____	STD	☐	☐	_____
Hepatitis	☐	☐	_____	Skin Problems	☐	☐	_____
High Blood Pressure	☐	☐	_____	Stomach/Intest Problems	☐	☐	_____
High Cholesterol	☐	☐	_____	Stroke	☐	☐	_____
HIV/AIDS	☐	☐	_____	Thyroid Disorders	☐	☐	_____
Injury Trauma - Major	☐	☐	_____	Varicose Veins	☐	☐	_____

9. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: _____

_____

10. **Social History:** (Only check what is pertinent to you)

☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits_____
☐ Caffeine Use ☐ Drug use (recreational, IV)

11. **Occupation:** _____ **Is your problem work related?** ☐ Yes ☐ No
12. **Are you currently pregnant?** _____
13. **Height:** _____ **Weight:** _____ **Shoe Size:** _____
14. **Your Medical doctors name**_____**Date of last visit** _____

Review of Systems

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

	Y	N
Constitutional:		
Generally do you feel well?	☐	☐
Do you feel fatigued during the day?	☐	☐
Eyes:	**Y**	**N**
Do you wear glasses or contacts?	☐	☐
Do you have burning or itchy eyes?	☐	☐
Do you have sensitivity to light?	☐	☐
Do you have watering of your eyes?	☐	☐
Are your eyes frequently red?	☐	☐
Do you have eye pain?	☐	☐
Ears, Nose and Throat:	**Y**	**N**
Do you have ringing in your ears?	☐	☐
Do you get nosebleeds?	☐	☐
Do you have difficulty swallowing?	☐	☐
Endocrine:	**Y**	**N**
Are you excessively thirsty?	☐	☐
Do you have a history of bad breath?	☐	☐
Are you experiencing night sweats?	☐	☐
Do you have swollen glands?	☐	☐
Have you had a significant weight change?	☐	☐
Respiratory:	**Y**	**N**
Do you have chest pain?	☐	☐
Do you have difficulty breathing?	☐	☐
Do you have shortness of breath?	☐	☐
Have you had a cough lasting longer than 3 weeks?	☐	☐
Cardiovascular:	**Y**	**N**
Have you noticed your legs or ankles swelling?	☐	☐
Do you have varicose veins?	☐	☐
Gastrointestinal:	**Y**	**N**
Do you have a loss or increase in appetite?	☐	☐
Do you have a history of stomach ulcers?	☐	☐
Do you frequently have heartburn?	☐	☐
Does aspirin cause stomach pain?	☐	☐
Do you have bloody or dark stools?	☐	☐
Hematologic/ Immunologic:	**Y**	**N**
Do you bruise easily?	☐	☐
If you get cut, does it take a long time to heal?	☐	☐
Genitourinary:	**Y**	**N**
Do you have pain with urination?	☐	☐
Have you noticed blood in your urine?	☐	☐
Musculoskeletal:	**Y**	**N**
Do you have low back pain?	☐	☐
Do you have painful joints?	☐	☐
Do you have general muscle aches or pains?	☐	☐
Have you had joint swelling?	☐	☐
Have you noticed a change in the way you walk?	☐	☐
Is foot pain reduced by avoidance of activity?	☐	☐
Do you limp when you walk?	☐	☐
Have you had joint stiffness?	☐	☐
Integumentary (Skin):	**Y**	**N**
Do you have any skin problems?	☐	☐
Is your skin strongly sensitive to sun?	☐	☐
Do you have any skin rashes?	☐	☐
Do you have any warts on your feet?	☐	☐
Do you have dry cracking skin?	☐	☐
Do you have any open skin sores?	☐	☐
Are your toenails unusually thick?	☐	☐
Are your toenails deformed?	☐	☐
Are your toenails ingrown or tender?	☐	☐
Do your toenails cause you pain?	☐	☐
Do you have problems with your fingernails?	☐	☐
Do you have hair loss on your legs or feet?	☐	☐
Neurological:	**Y**	**N**
Do you often feel dizzy?	☐	☐
Do you often feel confused?	☐	☐
Do you often feel disoriented?	☐	☐
Do you have problems with your balance?	☐	☐
Do you have frequent reoccurring headaches?	☐	☐
Do you have seizures?	☐	☐
" " involuntary movements of extremities?	☐	☐
Do your legs or feet go to sleep?	☐	☐
Do you have numbness in your legs or feet?	☐	☐
Do you get "burning" in your legs or feet?	☐	☐
" " experience leg/foot pain all the time?	☐	☐
" " experience shooting pain in legs/feet?	☐	☐
" " experience paralysis in your legs/ feet?	☐	☐
Psychiatric:	**Y**	**N**
Do you have a history of psychiatric problems?	☐	☐
Are you subject to mood swings?	☐	☐
Are you under a lot of stress?	☐	☐

Something you'd like us to know: