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 _________________
   - ☐ Aspirin _______________
   - ☐ Narcotic Agent / Codeine ________________
   - ☐ Anesthesia ________________
   - ☐ Shellfish _______________
   - ☐ Sulfa Drugs ___________________________
   - ☐ Nickel / Metal ______________
   - ☐ Radiographic Contrast Dye ____
   - ☐ Other ____

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__________________
    - ☐ Heart Disease _______________
    - ☐ Kidney Disease _________________
    - ☐ Hypertension ______________
    - ☐ Stroke ______________________
    - ☐ Mental Illness __________________
    - ☐ Rheumatology _____________
    - ☐ Bleeding Disorders ____________
    - ☐ Cancer ________________________
    - ☐ Other family History: ____

14. **Shoe size:** ______________ 15. **Height:** _________________ 16. **Weight**__________________

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	