ADVANCED PODIATRY GROUP

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PATIENT HISTORY

FULL NAME: _____ DATE: _____

AGE: _____

HEIGHT: _____

WEIGHT: _____

What is the main problem with your feet or ankles: _____

_____

_____

_____

When did you FIRST notice the condition: _____

Is this an injury: ☐ Y ☐ N

If yes, on what date did it occur: _____

If yes, did it happen at work: ☐ Y ☐ N

Are you claiming Workman's Comp: ☐ Y ☐ N

Check all the following that apply: **TYPE OF PAIN**

☐ Burning ☐ Tingling ☐ Sharp ☐ Dull Ache

☐ Shooting ☐ Stabbing ☐ Numbness ☐ Throbbing

WHEN PAINFUL

☐ Upon Standing ☐ During Walking ☐ After Walking

☐ During Sports ☐ Worse With Activity ☐ Better As Activity Continues

☐ Worse When Standing ☐ With Shoes ☐ Without Shoes

☐ Always ☐ Lying In Bed ☐ A.M. ☐ P.M

How painful is your condition: If **0** = No Pain & **10** = "The Worst Pain You Have Ever Experienced"

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have you had foot care before: ☐ Y ☐ N By Whom: _____ Date: _____

MEDICATIONS *(Please list all current prescription, over the counter, and supplements you are taking)*

Pharmacy *(If known)*: _____ Telephone #: _____

Medication	Dosage	How Often	Medication	Dosage	How Often
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

ALLERGIES

☐ NONE ☐ OTHER: _____

☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Aspirin ☐ Anesthetics ☐ Latex

☐ Codeine ☐ Demerol ☐ Darvocet ☐ Cortisone ☐ Environmental ☐ Food

MEDICAL HISTORY *(Please check any of the following conditions that you have or have had in the past)*

☐ Cancer; type: _____ ☐ OTHER: _____

☐ Neuropathy	☐ Tumors	☐ Epilepsy	☐ Fibromyalgia	☐ Heart Disease	☐ Arthritis
☐ Gout	☐ Asthma/COPD	☐ Skin Disorders	☐ MRSA	☐ Kidney Disease	☐ Anemia
☐ Tuberculosis	☐ Bursitis	☐ AIDS (HIV)	☐ Stomach Ulcers	☐ Lung Disease	☐ Sexually Transmitted Diseases
☐ Stroke	☐ Hepatitis	☐ Osteoporosis	☐ Colitis/Crohn's	☐ Mental Disorders	☐ Bleeding Problems
☐ Poor Circulation	☐ Joint Implants	☐ Thyroid Disease	☐ Sickle Cell	☐ Heart Burn/Reflux	☐ High Blood Pressure
☐ High Cholesterol	☐ Rheumatic Fever				

☐ Diabetes

What is the name of the doctor treating you for Diabetes: _____

Telephone #: _____

What was the date of your list visit: _____

What is your average blood sugar reading: _____

Are you pregnant:☐ Y ☐ N How many months: _____

SURGICAL HISTORY

Procedure	Date	Complications

Have you ever been hospitalized other than for surgery: ☐ Y ☐ N Explain: _____

_____

Have you ever had an injury to the lower extremity: ☐ Y ☐ N Explain: _____

_____

FAMILY HISTORY *(Please check all that apply)*

Diabetes:	☐ Father	☐ Mother	☐ Brother	☐ Sister
Heart Disease:	☐ Father	☐ Mother	☐ Brother	☐ Sister
High Blood Pressure:	☐ Father	☐ Mother	☐ Brother	☐ Sister
Gout:	☐ Father	☐ Mother	☐ Brother	☐ Sister
Cancer (what type):	☐ _____	☐ _____	☐ _____	☐ _____

SOCIAL HISTORY *(Please check all that apply)*

Date of last physical exam: _____

Occupation: _____

Recreational Activities: _____

Level of Activity: ☐ Occasional ☐ Weekly ☐ Competitive ☐ Professional

Do you smoke tobacco: ☐ Y # Packs Per Day ___ # Cigarettes Per Day ___ # Years smoking ___

☐ N Did you ever smoke: ☐ Y ☐ N

If you quit, how long ago did you stop smoking: _____

SOCIAL HISTORY CONTINUED *(Please check all that apply)*

Do you drink alcohol: ☐ Y ☐ N

If yes, how much: ☐ < 1 per week ☐ 1-2 per week ☐ 1-2 per day ☐ > 3 per day

Recreational drug use: ☐ Y* ☐ N

What substance & how often: _____

**Any type of drug use is a personal choice and will in no way adversely effect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.*

REVIEW OF SYSTEMS *(If you are experiencing any of the following please check the appropriate boxes)*

☐ ***I am not experiencing any of the below symptoms***

Head:	☐ Loss of Consciousness	☐ Concussions	☐ Dizziness	☐ Chronic Headaches		
Eyes:	☐ Glasses	☐ Contacts	☐ Double Vision	☐ Blurred Vision	☐ Blindness	☐ Cataracts
Ears:	☐ Decreased or Loss of Hearing	☐ Chronic Earaches		☐ Ringing in the Ears		
Nose:	☐ Drainage or Infection	☐ Blockage	☐ Bleeding	☐ Sinusitis		
Throat:	☐ Difficulty Swallowing	☐ Laryngitis	☐ Loss of Speech	☐ Chronic Tonsillitis		
Cardiovascular:	☐ Shortness of Breath	☐ Chest Pain	☐ Palpitations	☐ Murmurs	☐ Anemia	☐ Leg Cramps
	☐ Heart Valve Disease					
Respiratory:	☐ Difficulty Breathing	☐ Bronchitis	☐ Pneumonia	☐ Wheezing	☐ Chronic Cough	
Gastrointestinal:	☐ Weight Gain or Loss	☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Bloody Stool
	☐ Black Stool	☐ Excessive Gas	☐ Loss of Appetite			
Genitourinary:	☐ Chronic Kidney/Bladder Infections	☐ Problems Urinating		☐ Pain with Urination		
	☐ Dark or Bloody Urine	☐ Discharge from Penis or Vagina				

Do your legs swell: ☐ Y ☐ N

Do you have a back problems or have had a back injury: ☐ Y ☐ N

NOTICE OF PRIVACY PRACTICES (HIPAA REGULATIONS)

☐ You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet.

_____ _____

SIGNATURE **DATE**