

NEW PATIENT HISTORY FORM

NAME _____

DATE _____

Personal Health History

Are you diabetic? YES NO Diabetic Physician: _____

What Type of Diabetes Do You Have? How long have you had diabetes? _____

Do You Have Hepatitis? YES NO Attending Physician: _____

Are You HIV Positive? YES NO Attending Physician: _____

Do You Take Coumadin? YES NO Attending Physician: _____

Do You Smoke? YES NO If Yes - How many packs a day? _____ If No - NEVER or QUIT Smoking

Are you interested in quitting smoking? YES NO

Do You Use Alcohol? YES NO

Do You Use Recreational Drugs? YES NO

ALLERGIES

Please list all allergies - Include the type of reaction you have to the allergy

Name	Reaction You Had
_____	_____
_____	_____
_____	_____

ARE YOU ALLERGIC TO LATEX? YES NO TAPE? YES NO

MEDICATIONS: *(if you have a list we can copy it for you)- Please list over the counter drugs also*

<u>DRUG NAME</u>	<u>Dosage</u>	<u>Frequency</u>

FAMILY HISTORY

Please indicate any family history in the following areas - also indicate the family member

Condition	Mark if Yes	Family Members
DIABETES		
CANCER		
HEART CONDITIONS		
HIGH BLOOD PRESSURE		

CHIEF COMPLAINT

Please indicate the reason for your visit today:(include all complaints)

Have You Seen A Podiatrist Before? YES NO Date of Last visit: _____

Activites You Participate In: _____

EXERCISE

Sedentary (No Exercise)

Mild (ie; climb stairs, walk 3 blocks, golf

Occasional Vigorous Exercise: ie; work or recreation less than 4x/ week for 30 minutes

Regular Vigorous Exercise: ie, work or recreation 4x/ week for 30 minutes

Are You Dieting? YES NO

If Yes are you under a physican medical diet plan? YES NO

Diagnosed Medical Problems

AIDS / HIV	Diabetes	Kidney Disease
Alcoholism	Depression	Multiple Sclerosis
Anemia	Diverticulosis	Polio
Anorexia/ Bulemia	Drug Dependency	Psoriasis
Arthritis	Gout	Phychiatric Care
Asthma	Hay Fever/ Allergies	Rheumatic Fever
Bleeding Disorders	Heart Disease	Stroke
Blood Transfusions	Hepatitis	Ulcers
Cancer	High Blood Pressure	Other Illnesses:
Congenital Disorders		

PODIATRY HISTORY

Circle if you have or have had any of the following areas to a significant degree

Heel Pain / Arch Pain	Painful Corns	Recent Changes in Weig
Bunion Pain	Warts	Shooting Pain in Feet / I
Flat Feet	Rash on Foot	Ingrown Toenail
Numbness or Tingling In Feet	Itching of Feet	Gout
Trauma or Injury	Hammertoes	Other:
Ankle Pain	Circlation Problems	

PAST SURGERIES

Please List Any Surgeries and or Complications in the past 5 years

SURGERY

Year	Reason	Complication

Have you ever had a blood transfusion? YES NO

PLEASE PROVIDE US WITH YOUR CURRENT

HEIGHT _____ WEIGHT _____ SHOE SIZE _____

MEDICAL HISTORY (Please Circle)

Constitutional

Weight Loss
Fever
Chills
Weakness
Fatigue
Anxiety

Gastrointestinal

Anerexia
Nausea
Vomitting
Diahrrea
Abdominal Pain

HEENT/ EYES

Visual Changes
Blurred Vision
Double Vision

Respiratory

Shortness of Breath
Cough
Sputum

Genitourinary

Burning on Uriation
Frequent Unrination

Ears/ Nose. Throat

Hearing Loss
Sneezing
Congestion
Runny Nose
Sore Throat

Cardiovascular

Chest Pain
Chest Pressure
Swelling Feet/ Ankles
Palpitations
Edema
Cold Feet

Musculskeletal

Joint Stiffness
Joint Swelling
Pain in Walking
Muscle Pain

Hematologic

Anemia
Bruising
Bleeding

Skin

Rash
Itching
Sores not he

Endocrinol

Sweating
Cold Intoler
Heat Intoler
Excessive Th
Polyuria
Polydipsia

Neurological

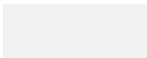
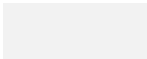
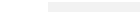
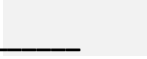
Headache
Dizziness
Numbness of Extremitie
Tingling of Extremities
Paralysis
Ataxia

Treatment Consent

I hereby give consent and permission for the doctor to treat me for the above conditions. He will inform me and include me in any decisions regarding the treatment of my feet, ankles and lower legs. To the best of my knowledge the above information is true and correct. I understand it is my responsibility to inform my doctor

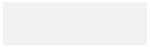
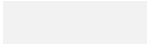
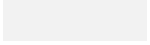
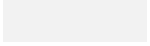
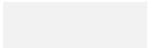
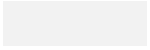
if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, or Guardian _____ **Date** _____

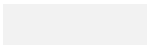
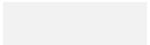


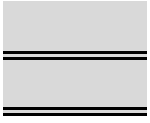
ency Taken





Weight
et / legs





not healing

rinologic

tolerance

tolerance

ve Thirst

mities
