PLEASE COMPLETE ALL PARTS OF THIS FORM. IT IS IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL QUESTIONS.

Name ________________________________ Age ____

Date of Birth ___________________________________

Birth Gender ___________ Gender Identity ___________

Primary Doctor's Name __________________________
(first) (last)

Date Last Seen by Primary _______________________

Pharmacy Name & Location _______________________

____

Past Medical History: "X" your current/past conditions	
○ AIDS/HIV	○ **Healing Problems**
○ Anemia	○ Heart Disease
○ **Anesthesia Problems**	○ Hepatitis
○ Anxiety/Depression	○ Hypertension
○ Arthritis	○ Kidney Disease
○ Asthma	○ Kidney Stones
○ Autoimmune Disorder	○ Leg/Foot Ulcers
○ Back Pain	○ Liver Disease
○ **Bleeding Disorder**	○ Lung Disease
○ **Blood Clot/DVT** Location:__________ Year:_____________	○ Organ Transplant: Type:_______________ Year:_______________
○ Cancer: Type__________	○ Osteoporosis
○ Coronary Artery Disease	○ Other Heart Issues
○ Diabetes: T1 or T2 ○ Year Dx:________	○ PTSD
Dialysis	○ Pacemaker
○ Dyslipidemia	○ Peripheral Vascular Disease
○ Edema	○ Pneumonia
○ Ehlers Danlos Syndrome	○ Pulmonary Embolism
○ Emphysema/COPD	○ Raynaud's Disease
○ Fibromyalgia	○ Rheumatoid Arthritis
○ Foot Deformity	○ Seizures/Epilepsy
○ Gout	○ Stroke
○ Headaches	○ Thyroid Problems
Other:	○ Varicose Veins

Social History:
Are you able to walk: **Yes** **No** **with Assistive Device**
Exercise Level: **None** **Occasional** **Moderate** **Heavy**
How many days per week: **1-2** **3-4** **5-7**
Are you currently in school: **Yes** **No**
Are you currently employed: **Yes** **No** **Retired**
Occupation: **N/A**
Do you or have you ever smoked tobacco: **Never** **Former Smoker** **Current Smoker**
What is your level of alcohol consumption: **None** **Occasional** **Moderate** **Heavy**
How many days per week: **1-2** **3-4** **5-7**
Do you use any illicit or recreational drugs: **Yes** **No**
What is your level of caffeine consumption: **None** **Occasional** **Moderate** **Heavy**
What is your relationship status: **Married** **Single** **Divorced** **Separated** **Widowed**
Shoe Size: Left _________ Right__________

Medications: Prescribed & Over the Counter		
Name	**Dose**	**Frequency**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

Allergies: Drugs & Reactions ⊿ **NKDA**
1.
2.
3.
4.

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Surgeries/Hospitalizations (Feet & All Others)	**Type/Date**
Ankle Surgery **Yes No Lt/Rt**	
Foot Surgery **Yes No Lt/Rt**	
1.	
2.	
3.	
4.	
5.	

Family History:

	Mom	Dad	Sister	Brother	Daughter	Son
AIDs/HIV						
Alzheimer's						
Anemia						
Anesthesia Problems						
Arthritis						
Asthma						
Bleeding Disorder						
Blood Clots						
Cancer						
Depression						
Diabetes						
Emphysema						
Eye/Vision Disorder						
Heart Disease						
Heart Attack						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Neurological Disorder						
Psychiatric Disorder						
Reynaud's Syndrome						
Seizures						
Stroke						
Thyroid Disease						
Ulcers: Foot/Leg						
Other:						

Review of Systems: Have you experienced any of these symptoms in the *last few weeks*?

General □fever □fatigue □chills □trouble sleeping □weakness □weight gain □weight loss

Head/Neck □dry eyes □irritation □vision change □eye disease/injury □wears glasses/contact lenses

ENMT □difficulty hearing □ear pain □frequent nosebleed □nose problems □sinus problems □sore throat □snoring □bleeding gums □dry mouth □mouth ulcer □sinusitis □mouth breathing □ringing in ears □oral abnormalities

Cardiovascular □chest/arm pain on exertion □palpitation □shortness of breath: walking □ankle swelling □shortness of breath: laying down □light-headed on standing

Respiratory □cough □wheezing □shortness of breath □coughing up blood □sleep apnea

Gastrointestinal □abdominal pain □nausea □vomiting □constipation □black or tarry stools □frequent diarrhea □vomiting blood □dyspepsia □GERD

Genitourinary □urinary loss of control □difficulty urinating □increased urinary frequency □incomplete emptying

Musculoskeletal □muscle aches □muscle weakness □arthralgias/joint pain □back pain □swelling in extremity □neck pain □difficulty walking □cramps □osteoporosis

Skin □jaundice □rash □itching □dry skin □growth/lesions □non-healing areas □psoriasis □change in skin color

Neurologic □loss of consciousness □numbness □seizures □dizziness □frequent or severe headaches □migraines □restless legs □tremor □gait dysfunction □paralysis

Psychiatric □depression/anxiety □alcohol abuse □agitation □hallucinations □suicidal thoughts □mood swings □memory loss □agitation □dementia □delirium

Hematologic/Lymphatic □swollen glands □anemia □easy bruising □excessive bleeding □phlebitis

Allergic/Immunologic □runny nose □sinus pressure □itching □hives □frequent sneezing

Other:

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

Signature:

Date:

Name:____Date of Birth:_____________________

What is bothering you today?____

____

____

How many months/years has this been going on?______________________________________

How did this happen?____

Did this happen while you were at work? ◯No ◯Yes, Is your employer aware? ◯No ◯Yes

Mark the location of the problem(s) with an X

If "0" is no pain or discomfort and "10" is the worst pain or discomfort you ever had, how would you rate your pain or discomfort today? (circle number)

(no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

Is your pain constant? ◯No ◯Yes

What have you done to treat it? Orthotic ______ Brace ______ Anti-inflammatory ______

Lotion/cream ______Antibiotic ______ Changed shoe _______ Ice _______Elevation______

What makes your symptoms worse?____

Signature: ____Date:___________________

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Name:______________________________DOB:_______________SSN:______________
Address:__________________________________City:____________________________
State:________ Zip:__________ Birth Gender:__________Gender Identity:____________
Preferred Phone:_____________________cell home Alternate Phone: ______________
Email: ________________________________Marital Status: Single Married Widow Divorced Separated
Employer:______________________________Job Title:_________________________
Employer Address:____
Work Phone:______________________________Is it OK for us to call you here? Yes No
How did you hear about us?____

Emergency Contact #1____________________________Relationship:______________
Phone:_________________________________Alternate Phone:__________________
Emergency Contact #2___________________________Relationship________________
Phone:_________________________________Alternate Phone:__________________

Primary Insurance:___________________________ID:__________________________
If the insurance is not in your name, please provide the following information:
Subscriber Name:_________________________Relation:______________DOB:__________
Secondary Insurance__________________________ID___________________________
Subscriber Name:_________________________Relation______________DOB__________

Race/Ethnicity

_____American Indian/Alaska Native _____Latino/Hispanic _____Black/African American
_____Native Hawaiian/Pacific Islander _____Asian _____White
_____Decline to specify

Preferred Language: English Other___________________________________
Is interpretation/translation needed for visits? Please circle one. **YES** **NO**

Is this visit due to an accident or traumatic injury? Yes No
If yes, have you filed or do you plan to file a workman's comp claim? Yes No

If the patient is a minor or is not their own guardian, please provide the information below:
Legal Guardian Name:______________________________Relation:________________
DOB:____________SSN:_________________________Phone:______________________
Address (if different from above):____

Signature:____**Date:**___________________
Relationship (if other than patient):____