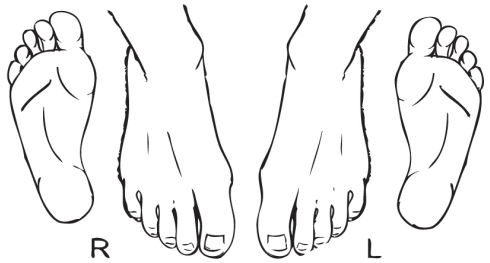
PODIATRIC HISTORY

Patient Name: _____
Are you in general good health? ___Yes ___No
Family Doctor: _____ Last Visit: _____
How often do you see your Family doctor? _____Why? _____
Have you seen a podiatrist before? ___Yes ___ No, if yes, Who? _____
For what reason, did you see your last podiatrist? _____
_____
Reason for today's visit: _____
_____
_____

On the Foot Diagram: Please mark accordingly:
-Mark with an 'X', where it's most painful
-Mark 'O', where it's sore.



Is your Pain: __Sharp __Burning __Dull Ache
__Sore __Throbbing __Bruised __Pins & Needles
Other _____
Onset: ___ Sudden ___ Gradual When did this start? _____
Frequency: ___ Constant ___ Intermittent
Timing: __ Weight Bearing __Non-weight Bearing
__Shoes Aggravate __During Work
__ Morning __Afternoon __Night
Other: _____
Cause/Etiology: ___Heredity ___Unknown __ Traumatic
Other: _____
Prior Treatment (include home and other doctor treatment): _____
_____
Are there any special treatment considerations that you think we should know about? _____
_____
Secondary Complaints & History: _____
_____
_____
Expectations: _____

Have you ever been told by a physician that you have:

__ AIDS	__ Bursitis	__ Heart Trouble	__Rheumatic Fever
__ Anemia	__ Cancer	__ High blood pressure	__ Stroke
__ Arthritis	__ Diabetes	__ Kidney Problems	__ TB
__ Asthma	__ Epilepsy	__ Liver Problems	__ Ulcers
__ Bleeding problems	__ Gout	__ Lung Problems	__ Varicose Veins
__Blood Clots	__Hardening of Arteries	__ Phlebitis (inflamed veins)	__ Thyroid Disorder

__ GI Problems __Other serious illness: _____

Are you subject to:

__Back Pain	__ Foot pain at rest	__Shortness of breath	Foot/Leg Cramps:
__Burning Pain	__Heartburn	__Swelling of Legs	__Night __Walking
__Chronic Infections	__Prolonged Bleeding		__None of the above

Prior surgery involving legs, ankles or feet? (please include who did the surgery and when): _____
_____
Do you smoke? __Yes __ No if yes, how much? _____Do you drink alcohol? __Yes __No How much? ____
If you are a Female, Are you Pregnant? __ Yes __ No

Has any member of your immediate family been treated for?

__Arthritis	__Diabetes	__High Blood Pressure
__Cancer	__Heart Disease	__Other foot problems?
		Explain_____