Patient Name: _____ **Date:** _____

History & Medical Information

1. **What is your foot/ankle problem** ☐ Right ☐ Left _____

   _____

2. **When did pain/discomfort begin (date):** _____

   Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

   What makes pain/discomfort worse: _____

   What makes the pain/discomfort better: _____

3. **Has problem been treated:** ☐ Yes ☐ No _____

4. **Past Medical History:**

☐ Anemia	☐ Gout	☐ Kidney Disease	☐ Other Arthritis
☐ Bleeding Disorders	☐ Heart failure	☐ Lung/Respiratory Disorders	☐ Prostate Disorders
☐ Cancer _____	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Diabetes	☐ High Cholesterol	☐ Nerve Disorders	☐ Stroke
☐ Epilepsy	☐ HIV / AIDS	☐ Neurological Disorders	☐ Thyroid Disorders
	☐ High blood pressure	☐ Osteoarthritis	☐ Other: _____

5. **List all medications/herbs/vitamins:** ☐ **NONE** _____

   _____

6. **Allergies:** (Describe reaction) ☐ **NONE**

   ☐ Penicillin _____ ☐ Aspirin _____ ☐ Narcotic Agent / Codeine _____
   ☐ Anesthesia _____ ☐ Shellfish _____ ☐ Sulfa Drugs _____
   ☐ Nickel / Metal _____ ☐ Radiographic Contrast Dye _____
   ☐ Other _____

7. **Are you currently pregnant?** ☐ Yes ☐ No _____

8. **Surgical History:** Have you had surgery? ☐ Yes—if yes, what and when ☐ No

   _____

   _____

9. **Social History:** (Only check what is pertinent to you)

   ☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits_____
   ☐ Caffeine Use ☐ Drug use (recreational, IV)

10. **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: _____

11. **Height:** _____ **Weight:** _____ **Age:** _____ **Shoe Size:** _____

For office use: B/P _____ Pulse _____ Resp. _____ Temp. _____

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	
☐ Jaw Pain	☐ Other		
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Joint Pain, Arthralgia	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions Infections	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Hair Loss	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth		
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Anxiety	☐ Depression