INDY PODIATRY
we love your feet
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HISTORY & MEDICAL INFORMATION

Patient Name: _____ Today's date: _____

1. Explain your foot/ankle problem: ☐ Left ☐ Right _____
2. When did pain/discomfort begin (date): _____

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

3. What makes the pain/discomfort better: _____
4. Have you had a physical trauma? ☐ No ☐ Yes _____
5. Have you had an accident? ☐ No ☐ Yes _____
6. Occupation: _____ Is your problem work related? ☐ Yes ☐ No
7. Past Medical History:

☐ Anemia
☐ Bleeding Disorders
☐ Cancer _____
☐ Diabetes (A1C _____)
☐ Epilepsy
☐ Gout
☐ Heart failure
☐ Hepatitis
☐ High Cholesterol
☐ High Blood Pressure
☐ HIV/AIDS
☐ Thyroid Disorders
☐ Lung/Respiratory Disorders
☐ Mitral Valve Prolapse
☐ Nerve Disorders
☐ Neurological Disorders
☐ Prostate Disorders
☐ Osteoarthritis
☐ Other Arthritis
☐ Stroke
☐ Kidney Disease
☐ Other_____

8. List all medications/herbs/vitamins: ☐ None _____

_____

9. Allergies (Describe reaction) ☐ **NONE**

☐ Penicillin_____
☐ Anesthesia_____
☐ Nickel/Metal_____
☐ Other_____
☐ Shellfish_____
☐ Aspirin_____
☐ Radiographic Contrast Dye_____
☐ Narcotic Agent/Codeine_____
☐ Sulfa Drugs_____

10. Are you currently pregnant? ☐ No ☐ Yes _____
11. Surgical History: Have you had surgery? ☐ No ☐ Yes –if yes, describe below

Surgery/Date: _____

_____

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

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

13. Family History: (List relationship of family member(s) who have had these problems):

☐ Diabetes _____
☐ Hypertension _____
☐ Rheumatology _____
☐ Heart Disease _____
☐ Stroke _____
☐ Bleeding Disorders _____
☐ Kidney Disease _____
☐ Mental Illness _____
☐ Cancer _____
☐ Other Family History: _____

14. Height: _____ Weight: _____ Shoe size: _____

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