SPARTAN PODIATRY PATIENT HISTORY

PATIENT NAME: _____

DATE: _____

HEIGHT____ WEIGHT_____ SHOE SIZE_____

SURGICAL AND HOSPITALIZATION HISTORY

PLEASE LIST PREVIOUS SURGERIES W/DATES

SURGERY _____

SURGERY_____

SURGERY_____

SURGERY_____

SURGERY_____

DO YOU HAVE METAL IMPLANTS? Y/N IF YES, WHAT KIND?_____
DO YOU SMOKE? □ # PER DAY_____ DO YOU DRINK ALCOHOL? □ #PER WEEK____

PARENT'S MEDICAL HISTORY

MOTHER: CANCER____ DIABETES_____ HIGH BLOOD PRESSURE_____
FATHER: CANCER____ DIABETES_____ HIGH BLOOD PRESSURE_____

PODIATRIC HISTORY

REASONS FOR YOUR VISIT TODAY:

_____
_____
_____

PLEASE INDICATE YOUR PAIN LEVEL FROM 1-10:_____

IS IT DULL? ___ SHARP?___ THROBBING?___ NUMB?___ TINGLING?___ CRAMPING?___

HAS THE PAIN WORSENED? ___ OR REMAINED THE SAME? ___

LOCATION OF FOOT/ANKLE/LEG PAIN: LEFT___ RIGHT___ OR BOTH___

IS THE PAIN WORSE IN THE MORNING? ___ EVENING?___ ALL DAY? ___

HOW LONG HAVE YOUR SYMPTOMS BEEN PRESENT? _____

WAS THE ONSET SLOW? ___ SUDDEN? ___ TRAUMATIC? ___

IF CAUSED BY TRAUMA, WAS IT DUE TO AN AUTO ACCIDENT? Y/N

OR AT WORK? Y/N

PREVIOUS TREATMENTS: _____
_____
_____

WHAT AGGRAVATES THE CONDITION? _____
_____

MEDICATIONS: PLEASE LIST BELOW OR ATTACH OWN LIST

NAME:_____ **DOSAGE:**_____ **REASON:**_____

NAME:_____ **DOSAGE:**_____ **REASON:**_____

NAME:_____ **DOSAGE:**_____ **REASON:**_____

NAME:_____ **DOSAGE:**_____ **REASON:**_____

NAME:_____ **DOSAGE:**_____ **REASON:**_____

NAME:_____ **DOSAGE:**_____ **REASON:**_____

NAME:_____ **DOSAGE:**_____ **REASON:**_____

NAME:_____ **DOSAGE:**_____ **REASON:**_____

MEDICAL HISTORY: PLEASE INDICATE IF YOU'VE BEEN TREATED FOR:

AIDS□
ACID REFLUX□
ANEMIA□
ANXIETY□
ARTHRITIS□
ARTIFICIAL HEART VALVE□
ARTIFICIAL JOINT □
ASTHMA□
BACK PROBLEMS
BLEEDING PROBLEMS□
BIPOLAR DISORDER□
BLOOD CLOT/DVT□
CANCER TYPE? ___
CHEMICAL DEPENDENCY□
CHEST PAIN/ANGINA□
CIRCULATORY PROBLEMS□
COPD□
DIABETES TYPE? ____ HOW LONG?_____ LAST A1C_____
DEPRESSION□
FIBROMYALGIA
GOUT□
HEADACHES□
HEART ATTACK□
HEPATITIS□
HIGH BLOOD PRESSURE□
KIDNEY PROBLEMS□
LIVER DISEASE□
LOW BLOOD PRESSURE□
NEUROPATHY□
PACEMAKER□
PHLEBITIS□
PSORIASIS□
SEIZURES□
STROKE OR TIA□
THYROID PROBLEMS□
HEART MURMUR□
OTHER_____

ARE YOU PREGNANT?□ BREASTFEEDING? □

ALLERGIES AND ADVERSE REACTIONS: PLEASE CIRCLE ALL THAT APPLY

ASPIRIN	**IVP DYE**	
LATEX	**TAPE/ADHESIVES**	**NICKEL**
PENICILLIN	**SULFA**	**IODINE**
BETADINE	**CODEINE**	**OTHER:**
TETANUS	**SHELLFISH**	_____

SPARTAN PODIATRY
PATIENT DEMOGRAPHICS

Patient contact information

NAME: _____

ADDRESS _____

PREFERRED PHONE NUMBER _____ E-MAIL _____

EMPLOYER NAME:_____
EMPLOYER PHONE NUMBER:_____
___
EMERGENCY CONTACT:_____PHONE:_____
RELATIONSHIP TO PATIENT:_____

IS THIS A WORK RELATED INJURY? Y/N IF YOU ANSWERED YES, PLEASE INFORM THE FRONT DESK.

VITAL INFORMATION

PCP AND PHONE: _____

PHARMACY AND PHONE: _____

ETHNICITY: HISPANIC/NON-HISPANIC DOB# M/F

INSURANCE INFORMATION