Spartan Podiatry

Name_____ Date of Birth_____ Date_____

PODIATRIC HISTORY

Reason for your visit: _____

_____

_____

Describe Type of Pain:
☐ Dull ☐ Sharp ☐Shooting
☐ Burning ☐ Aching
☐ Throbbing ☐ Tingling
☐ Numbness ☐ Cramping
☐Other: _____

Location: ☐ Right ☐ Left ☐ Both

☐ Foot ☐ Ankle ☐ Leg

Height: _____
Weight: _____
Shoe Size: _____

Duration (How long have your symptoms been present):_____Days/ Weeks/ Months/ Years

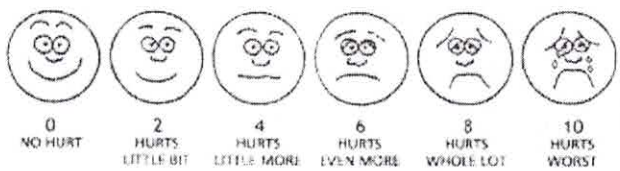
Onset: ☐ Slow ☐ Sudden ☐ Traumatic

If Traumatic: ☐ Auto ☐ Worker's Comp ☐ Other

Has Pain Become: ☐ Better ☐ Worse ☐ Stayed the same

Symptoms are worse:☐ Morning ☐ All Day ☐Evening ☐ Night

Please circle your pain level:



Previous Treatments: _____

_____

What aggravates the condition?

_____

_____

Who is your Primary Care Physician? Last time seen? _____

_____

May we contact physician regarding your care? ☐ YES ☐ NO

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MEDICATIONS

Please include prescriptions, over-the-counter medications, and vitamins or (Provide a list to be photocopied):

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

MEDICAL HISTORY

Please mark to indicate if you have or have been treated for any of the following:

Aids/HIV__
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__
Depression__
Diabetes__
Type__ How Long__
Emphysema__
Fibromyalgia__
Gout__
Headaches__
Heart Attack__
Heart Murmur__
Hepatitis__
High Blood Pressure__
Kidney Problems__

Liver Disease__
Low Blood Pressure__
Neuropathy__
Pacemaker__
Phlebitis__
Psoriasis__
Seizure Disorder__
Stroke or TIA__
Thyroid Problems__
Varicose Veins __

Other_____

Women, are you pregnant? Y N Breastfeeding Y N

MEDICATION ALLERGIES

Any allergies or adverse reaction to the following?

Local anesthesia __
Latex __
Penicillin __
Betadine __
Tetanus __

General anesthesia __
Anti-Inflammatory __
Iodine __
IVP dye __
Nickel __

Aspirin __
Tape/Adhesives __
Sulfa __
Codeine __
Shellfish ____

Other antibiotics (name) _____

Other medications (name) _____

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SURGICAL AND HOSPITALIZATION HISTORY

Please list previous surgeries and hospitalizations with approximate dates (year):

Surgery/Hospitalization_____ Date: _____

Surgery/Hospitalization_____ Date: _____

Surgery/Hospitalization_____ Date: _____

Surgery/Hospitalization_____ Date: _____

Do you have any metal implants? Yes NO

If so what kind of implant: _____

Do you smoke Y N #of Cigarettes/day _____

Do you drink Alcohol Y N # of drinks/day_____ #drinks/wk _____

Parents Medical History
Mother: Cancer:_____ Diabetes:_____ High Blood Pressure:_____
Father: Cancer:_____ Diabetes:_____ High Blood Pressure:_____

Please bring all forms to your appointment filled out completely. Please remember to bring all information with you to the appointment including Driver's License/Identification and Insurance Cards.

Signature: _____

Date: _____