Patient Name: _____ **Date:** _____

Referring Physician Name and Address: _____

History & Medical Information

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

_____

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

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

_____

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

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

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

11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: _____

_____

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

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

13. **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: _____		

14. **Shoe size:** _____

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