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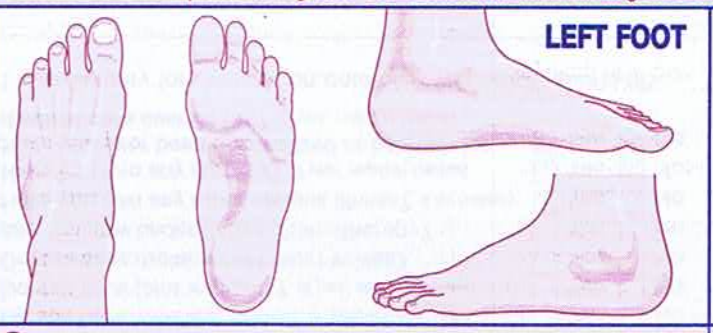
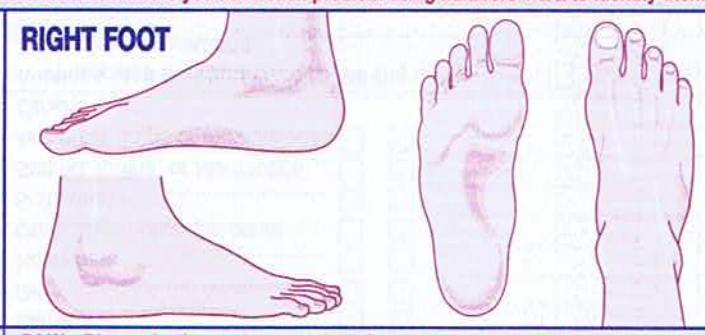
3 PATIENT'S CURRENT CHIEF COMPLAINTS CC/HPI

Patient CC# (s)

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below the areas where you have each problem using numbers 1 & 2 to identify them.





❶ Please mark the location of your first problem or pain on the diagrams above with a number **1**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡

My first problem is ... ☐ On Left foot ☐ On Right foot ☐ On Both feet.

It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it ...

_____ Is problem work related? Y N

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort:
0 None.... 1 Light ... 2 Moderate ... 3 Strong ... 4 Severe

My Pain/Discomfort is:
- ☐ Shooting Pain
- ☐ Throbbing Pain
- ☐ Sharp Pain
- ☐ Burning Pain
- ☐ Itching
- ☐ Aching Pain
- ☐ Tenderness
- ☐ Dull Pain
- ☐ Tingling
- ☐ Numbness

How long ago did the problem (pain) start?:
_____ ○ days, ○ weeks, ○ months, ○ years ago

The pain from my problem occurs:
☐ while walking and/or ☐ while not walking
☐ and/or: _____

Previous medical treatment(s) or home remedies:

❷ Please mark the location of your second problem or pain on the diagrams above with a number **2**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡

My second problem is ... ☐ On Left foot ☐ On Right foot ☐ On Both feet.

It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it ...

_____ Is problem work related? Y N

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort:
0 None.... 1 Light ... 2 Moderate ... 3 Strong ... 4 Severe

My Pain/Discomfort is:
- ☐ Shooting Pain
- ☐ Throbbing Pain
- ☐ Sharp Pain
- ☐ Burning Pain
- ☐ Itching
- ☐ Aching Pain
- ☐ Tenderness
- ☐ Dull Pain
- ☐ Tingling
- ☐ Numbness

How long ago did the problem (pain) start?:
_____ ○ days, ○ weeks, ○ months, ○ years ago

The pain from my problem occurs:
☐ while walking and/or ☐ while not walking
☐ and/or: _____

Previous medical treatment(s) or home remedies:

4 PATIENT'S DOCTORS - PLEASE TELL US WHOM TO THANK AND WITH WHOM TO COORDINATE YOUR CARE

My:	Physician's Name:	Phone Number	City	Date Last Seen	Referred me:	I was sent or came in especially for:		
Family/ Primary				/ /	Y N	2nd Opinion	Surgcl Eval	Consult
Specialist				/ /	Y N	2nd Opinion	Surgcl Eval	Consult
Other Podiatrist				/ /	Y N	2nd Opinion	Surgcl Eval	Consult

5 FOR DOCTOR'S USE - OBSERVATIONS & COMMENTS

☐ Patient was ○ assisted in completion of this record by or was ○ unable to complete without the help of: _____.

☐ Translation was done by _____ in ○ Spanish, ○ _____.

☐ Additional Information† obtained from ○ Family/Care givers and/or ○ Physician(s) _____

☐ Lab Reports† and/or ☐ Previous Medical Records† were reviewed. ☐ X-rays† brought by patient from _____ were reviewed.

† Elaborations: _____

I have reviewed the information provided above _____. ☐ My annotations to patient's entries are marked in: _____ (INK COLOR)

Doctor's Signature X _____ Date / / _____ MP ☐ See Additional Documentation

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☐ Only Changes To The Previous History Information Are Noted

PATIENT HISTORY

PATIENT NAME LAST, FIRST, MIDDLE _____

MEDICAL RECORD # OR LAST 4 DIGITS OF SSN _____

SEX _____ AGE _____ DOB / / _____

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