Record ID # 312556

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Confidential Office Medical Record

☐ Only Changes To The Previous History Information Are Noted

1 PATIENT IDENTIFICATION AND CONTACT INFORMATION

Patient Acct # Staff Entry

First Name: MI: Last Name:

Your type of Job Activity / Occupation:

☐ I prefer to be addressed as: Mr. Mrs. Miss Ms. Dr.

☐ I prefer to be addressed by: ○ First Name ○ Nick Name:

Last 4 digits of Socal Sec. #: Sex M / F Age Birth Date: / / Shoe Size: Weight: Height:

Phone Numbers For Contacting You:
Day: ( ) -
Evening: ( ) -
Cell/Pager: ( ) -

In Case of Emergency, Please Call:
Day: ( ) -
Evening: ( ) -

Please Provide Your Preferred Pharmacy:
Street / City:
Day: ( ) -

2 COMPREHENSIVE PATIENT MEDICAL HISTORY

ROS/PFSH

Have you had/been treated for:
☐ Warts ☐ Athlete's Foot
☐ Corns/Calluses ☐ Fungal Nails ☐ Ingrown nails
☐ Leg or Foot Ulcers ☐ Neuroma ☐ Foot Numbness
☐ Broken foot bone(s) ☐ Broken Ankle ☐ Ankle sprain
☐ Hammer/Mallet toes ☐ Bunions ☐ Flat feet
☐ Cramps in legs/feet ☐ Arch pain ☐ High arch feet
☐ Lower back pain ☐ Knee pain ☐ Heel pain
☐ Gait (Walking) problems ☐ In-toeing ☐ Toe walking
☐ Childhood foot problems ☐ Rash ☐ *NONE of these*

Did you previously or do you now wear:
Shoe inserts? Y N Still using them? Y N Do or did they help? Y N
Orthotics? Y N Still using them? Y N Do or did they help? Y N

The orthotics were obtained from: ○ Another Podiatrist ○ An Orthopedist ○ A Physical Therapist ○ A Chiropractor ○ Other:

Are your first steps out of bed painful? Y N ... then subsides? Y N
Do you get leg cramps ...during the Day? Y N ...at Night? Y N

Percent of waking hours spent on your feet? 20% 40% 60% 80% 100%

List the sports/type of dance your are active in:

Does foot pain limit your desired activities? ☐ Yes ☐ No
Do you have any difficulty in walking? ☐ Yes ☐ No
Any pain in calves or buttocks when walking? ☐ Yes ☐ No
Is the pain relieved by stopping & standing still? ☐ Yes ☐ No

Do you have or have you ever been treated for:
☐ Stroke ☐ Heart Attack ☐ High Blood Pressure
☐ Phlebitis ☐ Vascular Disease ☐ A Heart Condition
☐ Anemia ☐ Poor Circulation ☐ Eyes:Glaucoma/Manicular Deg.
☐ Diabetes ☐ Kidney Disease ☐ Keloid/Thick Scar
☐ Gout ☐ Osteoporosis ☐ Alzheimer's
☐ Sciatica ☐ Lyme's Disease ☐ Rheumatic Fever
☐ Arthritis ☐ Headaches ☐ Hearing/Ear Disorder
☐ Epilepsy ☐ Nerve Disorder ☐ Psychiatric Disorder
☐ Asthma ☐ Lung Disease ☐ Tuberculosis
☐ Hepatitis ☐ Liver Disease ☐ Thyroid Problem
☐ Dark Urine ☐ Chronic Light Stool ☐ Unexplained Weight Loss
☐ Cancer ☐ Stomach Ulcer ☐ *NONE of these*
☐ Other(s):

Do you have vascular grafts? *(If yes, explain below)* ☐ Yes ☐ No
Do you have joint implants? *(If yes, explain below)* ☐ Yes ☐ No
Do you have replacement heart valves? ☐ Yes ☐ No
Are you now under active chemotherapy? ☐ Yes ☐ No
Have you had any other serious illness? *(List below)* ☐ Yes ☐ No
Have you had any surgery? *(If yes, explain below)* ☐ Yes ☐ No
Have you ever been hospitalized or been under medical care over 24 hrs? *(If yes, explain below)* ☐ Yes ☐ No

I Had Surgery for: on date of: w/ complications of:

List relationship to you of family members who have had:
Diabetes Foot Problems
Arthritis Heart Attack
Stroke High Blood Pressure
Cancer Birth Defects

# of childbirths ___ Are you currently pregnant? ☐ Yes ☐ No
Are you slow to heal after cuts? ☐ Yes ☐ No
Any abnormal bruising, bleeding or scarring? ☐ Yes ☐ No
Do you smoke now? ☐ No ☐ Yes Packs/day ___ Years___
Did you ever smoke? ☐ No ☐ Yes Packs/day ___ Years___
If you quit, when did you do so?
Alcoholic beverages? *(Circle one)* None Rarely Moderately Daily Quit
Recreational Drugs? *(Circle one)* None Rarely Moderately Daily Quit
Please mark if you take vitamins or supplements that contain ○ *garlic,* ○ *Gingko biloba,* ○ *echinacea,* ○ *ginseng or* ○ *St. John's Wort*
Are you currently taking any medications? List below! ☐ Yes ☐ No
Are you taking Insulin? If yes, list below. ☐ Yes ☐ No

When noting frequency: A = As needed, x/ = times per D = day, W = week,

List: Medications	Dose?	How Often?	For Treatment of?
		A, x/ D W,	
		A, x/ D W,	
		A, x/ D W,	
		A, x/ D W,	
		A, x/ D W,	

Are you taking your medications as prescribed? ☐ Yes ☐ No

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

(Check the answer box that applies)	No	Yes	If yes, what happens?
Latex, Adhesive tape *(circle)*	☐	☐	
Penicillin	☐	☐	
Other antibiotics *(list below)*	☐	☐	
Empirin, Tylenol *(if yes, circle)*	☐	☐	
Aspirin, Advil, Aleve, or Motrin *(circle)*	☐	☐	
Celebrex	☐	☐	
Other pain remedies *(list below)*	☐	☐	
Morphine	☐	☐	
Codeine	☐	☐	
Demerol	☐	☐	
Other narcotics *(list below)*	☐	☐	
Novocaine	☐	☐	
Other anesthetics *(list below)*	☐	☐	
Sulfa drugs	☐	☐	
Shrimp, Iodine, or Merthiolate	☐	☐	
Any other drugs or medications.	☐	☐	

Others:

Anything else that you want to tell the doctor? ☐ Yes ☐ No
Illnesses/Explanations:

INITIAL HISTORY ☐ UPDATE OF HISTORY TAKEN ☐ PATIENT HISTORY AS OF ___/___/___

PLEASE CONTINUE ON THE OTHER SIDE TO PROVIDE ADDITIONAL DETAILS.

Patient CC# (s)