

FOOT HEALTH INFORMATION:

SHOE SIZE _____

HEIGHT _____

WEIGHT _____

What are your current foot/ankle problems: (Be Specific)

RIGHT FOOT

LEFT FOOT

BILATERAL

When did your problems begin? _____

Have you been treated for this previously? Yes No

If yes, when were you treated and by whom?

Are you under the care of Pain Management? Yes No

Are you on a Pain Management Contract? Yes No

Is your injury work related? (BWC) Yes No

PAST MEDICAL HISTORY:

Please check all that apply

ENDOCRINE: Diabetes Thyroid Hypertension

SYSTEMIC DISEASE: Hepatitis Aids Renal Failure

Please list any additional history not covered above:

For diabetic patients:

How many years have you been diagnosed as a diabetic? _____ Type I Type II

Last blood sugar reading: _____ Result: _____

Last A1C: _____ Date: _____

Last vision exam: _____ Result: _____

SURGERY HISTORY:

Check if this does not apply to you

_____ Location _____

_____ Location _____

_____ Location _____

_____ Location _____

_____ Location _____

HOSPITALIZATION HISTORY:

Check if this does not apply to you

_____ Location _____

_____ Location _____

_____ Location _____

_____ Location _____

_____ Location _____

FAMILY HISTORY:

Check if this does not apply to you

Arthritis _____ Mother Father Sister Brother

Cancer _____ Mother Father Sister Brother

Diabetes _____ Mother Father Sister Brother

Foot Problems _____ Mother Father Sister Brother

Heart Disease _____ Mother Father Sister Brother

High Blood Pressure _____ Mother Father Sister Brother

Father: Alive Deceased Died of: _____ Age: _____

Mother: Alive Deceased Died of: _____ Age: _____

SOCIAL HISTORY:

Please check all that apply

Tobacco Packs/Day _____ # of Years _____ Quit? Yes No

Alcohol Drinks/Day _____ Type _____

Exercise Days/Week _____ Type _____

Caffeine Drinks/Day _____ Type _____

Pregnant Due Date _____

Seatbelt use 100% 75% 50% 25% 0%

Sun exposure Frequently Occasionally Rarely

MEDICATIONS:

Check if this does not apply to you

Medication Name

Dosage

Instructions

Prescriptions

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over the Counter

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins

_____	_____	_____
_____	_____	_____

Herbal

_____	_____	_____
_____	_____	_____

ALLERGIES:

Check if this does not apply

Penicillin	Reaction _____	Iodine	Reaction _____
Novocain	Reaction _____	Latex	Reaction _____
Codeine	Reaction _____	Other	Reaction _____
Adhesive Tape	Reaction _____	Other	Reaction _____
Sulfa	Reaction _____	Other	Reaction _____