

**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. Are you currently pregnant?  No  Yes \_\_\_\_\_

8. Past Medical History:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Lung/Respiratory Disorders	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Other Arthritis
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Nerve Disorders	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Neurological Disorders	<input type="checkbox"/> Stroke
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Prostate Disorders	<input type="checkbox"/> Kidney Disease
			<input type="checkbox"/> Other: _____

9. List all medications/herbs/vitamins:  NONE \_\_\_\_\_  
 \_\_\_\_\_

10. Allergies: (Describe reaction)  NONE

<input type="checkbox"/> Penicillin _____	<input type="checkbox"/> Aspirin _____	<input type="checkbox"/> Narcotic Agent / Codeine _____
<input type="checkbox"/> Anesthesia _____	<input type="checkbox"/> Shellfish _____	<input type="checkbox"/> Sulfa Drugs _____
<input type="checkbox"/> Nickel / Metal _____	<input type="checkbox"/> Radiographic Contrast Dye _____	
<input type="checkbox"/> Other _____		

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)

<input type="checkbox"/> Tobacco Use	<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Exercise habits _____
<input type="checkbox"/> Caffeine Use	<input type="checkbox"/> Drug use (recreational, IV)	

13. Family History: (List relationship of family member(s) who have had these problems):

<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Mental Illness _____
<input type="checkbox"/> Rheumatology _____	<input type="checkbox"/> Bleeding Disorders _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Other family History: _____		

14. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe size: \_\_\_\_\_

<p><b>For office use:</b> B/P _____ Pulse _____ Resp. _____ Temp. _____</p>
---

## Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced**.

<b>Constitutional</b>			
<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Sweats	<input type="checkbox"/> Weight Change
<b>Head, Eyes, Ears, Nose and Throat</b>			
<input type="checkbox"/> Wear Contact Lenses	<input type="checkbox"/> Dentures	<input type="checkbox"/> Wearing Eyeglasses	
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Cataract	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Sore Throat	
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Problems with eyesight	<input type="checkbox"/> Ringing in the Ears	
<b>Cardiovascular</b>			
<input type="checkbox"/> Chest Pain / Discomfort	<input type="checkbox"/> Cardiovascular Symptom	<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> Swelling lower extremity	<input type="checkbox"/> Leg Pain with Exercise	<input type="checkbox"/> Palpitations	
<b>Hematologic/Lymphatic</b>			
<input type="checkbox"/> Bleeding Problem	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Lymphoma	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Skin Lump - Location		
<b>Respiratory</b>			
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Previous Pulmonary Disease	
<input type="checkbox"/> Exposure to TB	<input type="checkbox"/> Cough	<input type="checkbox"/> Pulmonary Symptoms	
<b>Gastrointestinal</b>			
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Decrease in Appetite	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Constipation	
<b>Endocrine</b>			
<input type="checkbox"/> Often Thirsty	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Urinary Symptoms	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Prior Kidney Disease	
<b>Musculoskeletal</b>			
<input type="checkbox"/> Musculoskeletal symptoms	<input type="checkbox"/> Feeling weak	<input type="checkbox"/> Joint Pain, Arthralgia	
<input type="checkbox"/> Weakness of limbs	<input type="checkbox"/> Prior Fracture		
<b>Nervous System</b>			
<input type="checkbox"/> Ataxia	<input type="checkbox"/> Speech Difficulties	<input type="checkbox"/> Headache	
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Confusion/ Disorientation	<input type="checkbox"/> Fainting	
<input type="checkbox"/> Convulsions			
<b>Skin</b>			
<input type="checkbox"/> Rash	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Lesions	<input type="checkbox"/> Sun Sensitivity
<input type="checkbox"/> Color Change	<input type="checkbox"/> Slow Healing	<input type="checkbox"/> Infections	<input type="checkbox"/> Cracking
<input type="checkbox"/> Eczema (Pruritus)	<input type="checkbox"/> Growth	<input type="checkbox"/> Hair Loss	
<b>Allergic, Immunologic History</b>			
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Lupus	<input type="checkbox"/> Collagen Vascular
<b>Psychiatric</b>			
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tension	<input type="checkbox"/> Depression	