Patient: ___________________________________

History & Medical Information

Chart # Date:

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. **What makes the pain/discomfort worse:**____

5. **Has condition been treated?** ☐ yes ☐ no ____

6. **Past Medical History:**

☐ Anemia	☐ Hepatitis	☐ Coronary artery disease/ heart attack	☐ Sleep Apnea
☐ Bleeding Disorders	☐ HIV / Aids	☐ Mitral Valve Prolapse	☐ Kidney Disease
☐ Arthritis	☐ Ulcer	☐ Irregular, missed or extra heartbeat	☐ Prostate disorders
☐ Cancer _____________	☐ Esophageal reflux	☐ Heart Murmur	☐ Thyroid Disorders
☐ Gout	☐ High blood pressure	☐ Nerve/Neurological Disorders	☐ Other:____________
☐ Diabetes	☐ Stroke / TIA	☐ Lung/Respiratory Disorders	__________________
☐ Epilepsy	☐ High Cholesterol	☐ Asthma	__________________
	☐ Heart failure	☐ Tuberculosis	

7. **List all medications/herbs/vitamins:** ☐ **NONE** ____

____

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

   ☐ Penicillin _________________ ☐ Aspirin _______________ ☐ Narcotic Agent / Codeine ________________

   ☐ Anesthesia ________________ ☐ Shellfish _______________ ☐ Sulfa Drugs _______________

   ☐ Nickel / Metal _____________ ☐ Radiographic Contrast Dye ______________________________

   ☐ Other ____

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

   Surgery / Date: ____

____

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

    ☐ Tobacco Use ☐ Caffeine Use ☐ Exercise habits____________________________________

    ☐ Alcohol Use ☐ Drug use (recreational, IV)

11. **Job:** __________________________ **Job requirements: %** Sitting________ **%**Standing_________ **%**Lifting_______

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

    ☐Diabetes _____________ ☐ Heart Disease_____________ ☐ Bleeding Disorders ______________

    ☐ Cancer _____________ ☐ Kidney Disease____________ ☐ Mental Illness _________________

    ☐ Stroke _____________ ☐ Rheumatoid arthritis ___________ ☐ High Blood Pressure ____________

    ☐ Other family History: ____

13. **Height:** ______________________ **Weight** _____________________ **Shoe Size:**__________________________

For office use: B/P _____________ Pulse ________ Resp. ________ Temp. ___________

Review of Systems

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

Constitutional:	**Y**	**N**
Generally do you feel well?		
Do you feel fatigued during the day?		
Does your problem limit your normal daily activities?		
Do you have a fever?		

Cardiovascular:	**Y**	**N**
Have you noticed your legs or ankles swelling?		
Do you have varicose veins?		
Do you have cramping in your legs at night or at rest?		
Do you have cramping in your legs or calf when walking?		

Respiratory:	**Y**	**N**
Do you have chest pain?		
Do you have difficulty breathing?		
Do you have shortness of breath?		
Have you had a cough lasting longer than 3 weeks?		

Musculoskeletal:	**Y**	**N**
Do you have low back pain?		
Do you have pain in your legs?		
Do you have foot pain?		
Do you have joint pain?		
Do you have bone pain?		
Do you have general muscle aches or pains?		
Have you had swelling in your legs?		
Have you had joint swelling or stiffness?		
Have you noticed a change in the way you walk?		
Is it difficult to climb stairs?		
Are you experiencing a loss of strength in your legs?		
Do you limp when you walk?		
Do your shoes wear out quickly or unevenly?		

Integumentary (Skin):	**Y**	**N**
Do you have any skin problems?		
Is your skin strongly sensitive when exposed to the sun?		
Do you have any skin rashes?		
Do you have any warts on your feet?		
Do you have any moles, lumps or bumps on your skin?		
Do you have extremely dry skin or cracking?		
Do you have any open skin sores?		
Are there unusual areas of discoloration on your skin?		
Do you have any corns or calluses on your feet?		
Are your nails unusually thick?		
Are your nails deformed?		
Are your nails ingrown and tender?		
Do your nails cause you pain?		
Do you have problems with your fingernails?		
Do you have noticeable hair loss on your legs or feet?		

Allergic / Immunologic:	**Y**	**N**
If you get cut, does it take a long time to heal?		
Do you have allergic reactions to medication, foods, dye?		

Eyes:	**Y**	**N**
Do you wear glasses or contacts?		
Do you have burning or itchy eyes?		
Do you have sensitivity to light?		
Are your eyes frequently red?		
Do you have eye pain?		

Ears, nose, mouth & throat:	**Y**	**N**
Do you have ringing in your ears?		
Do you get nosebleeds?		
Do you have difficulty swallowing?		

Gastrointestinal:	**Y**	**N**
Do you have a loss of increase in appetite?		
Does Aspirin cause stomach pain?		
Do you have a history of stomach ulcers?		
Do you have heartburn?		
Do you have bloody or dark stools?		

Genitourinary:	**Y**	**N**
Do you urinate more frequently than before?		
Do you have pain with urination?		
Do you have burning with urination?		
Have you noticed blood in your urine?		

Neurological	**Y**	**N**
Do you ever feel dizzy?		
Do you **often** feel confused or disoriented?		
Do you have problems with your balance?		
Do you have frequent or reoccurring headaches?		
Do you have seizures?		
Do you have tremors of your extremities?		
Do your legs **often** feel like they "are going to sleep"		
Do you have numbness in your legs?		
-a feeling of burning in your legs?		
-cramps or pain in the legs with walking or exercise?		
-leg pain that is worse at night or at rest?		
-leg pain all the time?		
-experience shooting pains down your legs?		
- paralysis (complete loss of muscle strength in legs)		

Psychiatric:	**Y**	**N**
Do you have a history of psychiatric problems?		
Are you subject to mood swings?		
Are you under a lot of stress?		

Endocrine:	**Y**	**N**
Do you urinate more frequently than before?		
Are you excessively thirsty?		
Do you have a history of bad breath?		
Are you experiencing night sweats?		
Do you have swollen glands?		
Have you had a significant weight change recently?		

Hematologic / Lymphatic	**Y**	**N**
Do you bruise easily?		