RNV Podiatry
FOOT AND ANKLE SPECIALISTS

PATIENT HISTORY

Date: ____ /____ /____ Name _____

PATIENT HISTORY

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

1) What is the main problem with your feet or ankles? _____

_____

_____

_____

2) When did you first notice the condition? _____

_____

_____

_____

3) Is this an injury? ____Yes ____ No

If Yes, when did it occur? ____ /____ /____

If Yes, did it happen at work? ____Yes ____ No

Are you claiming Workman's Comp? ____Yes ____ No

4) Check all of the following that apply:

Type of Pain ◯ Burning ◯ Tingling ◯ Sharp ◯ Dull Ache ◯ Throbbing
◯ Shooting ◯ Stabbing ◯ Numbness

When Painful ◯ Upon Standing ◯ During Walking ◯ After Walking
◯ During Sports ◯ Worse with Activity ◯ Better as Activity Continues
◯ Worse when standing ◯ With Shoes ◯ Without Shoes
◯ A.M ◯ P.M ◯ Lying in Bed ◯ Always

5) How painful is your condition?

If 0 = "no pain" and 10 = "the worst pain you have ever experienced", please circle your pain level:

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

6) How has this affected your daily routine and what activities does this keep you from performing? _____

_____

_____

_____

7) Have you had foot care before? ____Yes ____ No

By whom and when: _____

_____

_____

_____

PATIENT HISTORY

MEDICATIONS

Pharmacy: _____ Number: _____-_____-_____

Medication	Dosage	How Often Taken?	What is it Taken for?

ALLERGIES

◯ NONE ◯ OTHER _____

◯ Penicillin ◯ Sulfa ◯ Iodine ◯ Aspirin ◯ Anesthetics ◯ Latex

◯ Codeine ◯ Demerol ◯ Darvocet ◯ Cortisone ◯ Environmental ◯ Food

Type of Reactions: _____

MEDICAL HISTORY

Please check any of the following conditions that you have or have had in the past.

◯ Diabetes ◯ Heart Disease ◯ Poor Circulation ◯ Heartburn / Reflux ◯ Thyroid Disease

◯ Stroke ◯ High Blood Pressure ◯ Asthma ◯ Colitis / Crohn's Disease ◯ Rheumatic Fever

◯ Epilepsy ◯ High Cholesterol ◯ Lung Disease ◯ Stomach Ulcers ◯ Arthritis

◯ Sickle Cell ◯ Kidney Disease ◯ Tuberculosis ◯ Hepatitis ◯ Osteoporosis

◯ Gout ◯ Skin Disorders ◯ Glaucoma ◯ AIDS (HIV) ◯ Bleeding Disorder

◯ Cancer; type _____

◯ Other: _____

◯ Diabetes; What is the name, phone number, and address of the doctor treating you for diabetes? _____

_____

_____

_____

When was your last visit? ____ /____ /____ What is your average blood sugar reading? _____

Are you pregnant? ____Yes ____ No How many months? _____

PATIENT HISTORY

SURGICAL HISTORY

Procedure	Date	Complications

1) Have you ever been hospitalized other than for surgery? ____Yes ____ No Explain _____

_____

_____

2) Have you ever had an injury to the lower extremity? ____Yes ____ No Explain _____

_____

_____

FAMILY HISTORY

Please check all that apply

	Father	Mother	Brother	Sister
Diabetes				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Stroke				
Cancer (what type)				
Other				
Alive or Deceased				

PATIENT HISTORY

SOCIAL HISTORY

Date of last physical Exam: ____/____/____ Occupation:_____

Activities: _____

Level of activity: ____ Occasional ____ Weekly ____ Competitive ____ Professional

Do you smoke tobacco? ____Yes ____ No

If Yes: # packs per day? ____ # cigarettes per day? ____ # of years smoking? ____

If No: Did you ever smoke? ____Yes ____ No

If Yes: How long ago did you stop smoking? _____

Do you drink alcohol? ____Yes ____ No

If Yes, what type: ____Beer ____ Wine ____Hard Liquor

If Yes: How much? ____ < 1 per week ____ 1-2 per week ____ 1-2 per day ____ more than 3 per day

RECREATIONAL DRUG USE

Any type of drug use is a personal choice and will in no way adversely effect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer: ____Yes ____ No If Yes: What substance and how often used? _____

REVIEW OF SYSTEMS

If you are experiencing any of the following please circle

HEAD: chronic headaches, concussions, dizziness, loss of consciousness.
EYES: glasses, contacts, double vision, blurred vision, blindness, cataracts.
EARS: decreased or loss of hearing, ringing in the ears, chronic earaches.
NOSE: drainage or infection, blockage, bleeding, sinusitis.
THROAT: chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech.
CARDIOVASCULAR: chest pain, shortness of breath, palpitations, murmurs, heart valve disease, anemia, leg cramps.
RESPIRATRORY: bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough.
GASTOINTESTINAL: nausea, vomiting, diarrhea, constipation, weight gain or loss, blood in stool, black stool, excessive gas, loss of appetite.
GENITOURINARY: chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine, discharge from penis or vagina.
GYNECOLOGIC: Irregular or painful periods, absence of period if not in menopause, vaginal discharge.
Other: _____

Do your legs swell? ____Yes ____ No
Do you have back problems or have had a back injury? ____Yes ____ No

◯ I am not experiencing any of the above symptoms.