

New Patient/Update Consultation

Patient name: _____ Age: _____
Ht _____ Wt _____ Shoe size _____
Vitals: BP _____ Pulse _____ Resp _____ Temp _____
MD/DO _____

How did you hear about us? Family/friend/patient/newspaper/PhoneBook/radio/tv/insurance company/ employer/other _____
Medications: _____

Family history: mother/father/brother/sister: diabetes/heart disease/cancer/high bp/other _____

Foot problem(s): _____

Where: _____ How long? _____ days/wks/mos/yrs

Pain scale (1-10) _____ Describe pain _____

Cause of foot problem: injury/deformity/unknown/ other _____

Aggravated by: walking/standing/shoes/physical activity

Treatment provided in the past: PCP/foot doctor/chiropractor/orthopedic surgeon/physical therapist/ER doctor

Treatment: X-rays/taping padding/medication/injections/orthotics/wound care/ foot surgery

Type of foot surgery _____

Foot doctors seen in the past and when: _____

Have you ever had (circle all that apply): bunions/hammertoes/heel spurs/corns/ calluses/ingrown toenails/fungus toenails/athlete's foot/warts/flat feet/high arches/pinched nerves

Do you regularly take: blood thinners? (aspirin, Coumadin, vitamin E) Cortisone or other steroids? _____

Past/current medical history (circle all that apply):

- | | |
|--|--------------------------------|
| Diabetes (controlled by: insulin/pills/diet) | Bladder/kidney/urinary trouble |
| High BP/stroke | Parkinson's/Alzheimer's |
| Heart attack/leaky valve | Headaches/depression/anxiety |
| Irregular heartbeat/congestive heart failure | Skin trouble/rashes |
| High cholesterol | Leg/foot sores/ulcers |
| Cancer (type) _____ | Dentures/glasses |
| Epilepsy | Thyroid trouble |
| Osteoarthritis/rheumatoid arthritis | Joint replacement |
| Degenerative joint disease/gout | Bleeding problems/anemia |
| Poor circulation/varicose veins | Blood clots |
| Cirrhosis/hepatitis | Slow wound healing |
| Asthma/bronchitis/COPD | Hayfever/allergies |
| Stomach/bowel problems | Surgical complications |

Medication/substance allergies (circle all that apply):

Latex/tape/ iodine/ivp dye/shellfish

Have you ever taken a medication that caused a skin rash, facial swelling, or difficulty breathing? Y / N If yes, please list medication name and reaction:

Have you ever taken a medication that caused vomiting, nausea, dizziness, diarrhea, or headache? Y / N If yes, please list medication name and reaction:

Have you ever had trouble with spinal, general, or local anesthesia? Y / N If yes, please explain:

Social history

Single / married / widowed / divorced Occupation _____

Current smoker? If so, how many packs/cigs per day? _____

How long have you been smoking? _____

If former smoker, quite date: _____

Alcohol: How many drinks per day/week/month? _____

Surgeries / hospitalizations / childbirth history (list dates/procedures):
