Preferred name ___________________

Last Name ____ **First Name** ____________________________________ **MI** __________

Date of Birth _________ **Age** _________ **Gender M / F Email** ________________ **Social Security #**________________

Employer ____ **Occupation** ____

Name of person responsible for bill ___________________________ **Spouse/parent's name** _________________________________

Emergency Contact ______________________________ **Relationship** ___________________ **Phone** (_____)_______________

Describe your foot problem:____

How long has it been bothering you? ____________________ **Pain severity? (Scale from 0 - 10)** ____________

What treatments (if any) have you received/tried for this condition? ____

Any past problems with your feet or ankles? ____

Allergies ____

Medications ____

____

Surgical History (type & year) ____

Please check all boxes that apply to you. Write in any missing information

Past Medical History ☐ **None**

- ☐ **AIDS/HIV**
- ☐ **Anemia**
- ☐ **Alcoholism/Drug Dependency**
- ☐ **Alzheimers/Dementia**
- ☐ **Arthritis-Location:** _______________
- ☐ **Artificial Joints - Location:** _________
- ☐ **Asthma**
- ☐ **Back Injury/Pain**
- ☐ **Bleeding Disorder**
- ☐ **Blood Clots**
- ☐ **Cancer – Type:**_________________
- ☐ **Depression/Anxiety (circle)**
- ☐ **Diabetes – Type 1 or 2 A1C** _______
- ☐ **Dialysis**
- ☐ **Edema**
- ☐ **Fibromyalgia**
- ☐ **Gout**
- ☐ **Heart Disease/Failure**
- ☐ **Heart Valve Implant/Defibrillator**
- ☐ **Hepatitis**
- ☐ **High Blood Pressure**
- ☐ **Kidney Disorder** _________________
- ☐ **Leg or Foot Ulcers**
- ☐ **Liver Disease** ____________________
- ☐ **Lung Problems** __________________
- ☐ **Neurological Disorder** ____________
- ☐ **Organ Transplant**
- ☐ **Osteoporosis**
- ☐ **Pacemaker**
- ☐ **Peripheral Vascular Disease**
- ☐ **Rheumatoid Arthritis**
- ☐ **Sleep Apnea – CPAP (yes / no)**
- ☐ **Skin Condition:**________________
- ☐ **Stomach/Intestinal Problems (Acid Reflux, Heartburn, GERD)**
- ☐ **Stroke**
- ☐ **Thyroid Disease (Goiter, low, high)**
- ☐ **Other:**

Family History ☐ **None D – Dad, M – Mom**
Please list:

Review of Systems ☐ **None**

- ☐ **Headache**
- ☐ **Recent Weight Loss**
- ☐ **Weakness/fatigue**
- ☐ **Recent Vision Changes**
- ☐ **Change in skin and nails**
- ☐ **Joint pain/Stiffness**
- ☐ **Numbness/tingling in feet**
- ☐ **Pregnant**
- ☐ **Blood in urine**
- ☐ **Frequent urination**
- ☐ **Decreased circulation to legs**
- ☐ **Excessive thirst/hunger**
- ☐ **Shortness of breath**
- ☐ **Nausea/vomiting**
- ☐ **Chest pain**
- ☐ **Heart murmur**
- ☐ **Depression**
- ☐ **Other:** ________________________

Tobacco use YES NO (_____packs/day x _____yrs) **Former Tobacco User YES NO Alcohol Use YES NO**

Height _________ft _______in **Weight** ______________ **Shoe Size**______________

Referring Doctor's Name:____________________________ **Primary Doctor's Name:**__________________________

Preferred Pharmacy ____