Name: _____ Sex: M F

Date of Birth: _____ Adddress: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Job description: _____

Have you ever been seen by a podiatrist before? _____

Who referred you to us? _____

Reason for today's visit: _____

Previous treatment: _____

Onset: _____ Duration: _____ Pain level: _____ Injury: Yes No

How is your general health? _____

Do you have any of the following? ☐ Diabetes (type _____) ☐ Circulatory condition/blood thinner

REVIEW OF SYSTEMS:

General
- ☐ Recent antibiotics
- ☐ Excessive thirst
- ☐ Pregnant

Respiratory
- ☐ Difficulty breathing
- ☐ Shortness of breath

Musculoskeletal
- ☐ Pain
- ☐ Weakness
- ☐ Joint/leg swelling
- ☐ Rheumatoid arthritis
- ☐ Difficulty walking

Neurological
- ☐ Numbness
- ☐ Tingling
- ☐ Burning
- ☐ Drop foot

Other
- ☐ _____

Cardiovascular
- ☐ Irregular heartbeat
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Leg cramps
- ☐ Stent
- ☐ Valvular disease

CURRENT MEDICATIONS: _____

_____

DRUG ALLERGIES: _____

PAST ILLNESS HISTORY:

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer _____
- ☐ Claudication
- ☐ DVT
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart disease
- ☐ Hypertension
- ☐ Mitral valve prolapse
- ☐ Psoriasis
- ☐ Resting leg pain
- ☐ Rhematoid arthritis
- ☐ Rheumatic fever
- ☐ _____
- ☐ _____

PAST SURGICAL HISTORY:

☐ Back ☐ Cardiac/Bypass ☐ Hand/wrist ☐ Foot/ankle ☐ Hip ☐ Knee

☐ Do you have any artificial joints? If yes, where? _____

By signing below:

I certify that the above is true and correct to the best of my knowledge.

I give my consent to be treated by Dr. Daniel B. DePalma.

I understand that Dr. Daniel B. DePalma does not participate with any insurances and I am responsible for the cost of this visit at the time of service.

I have received a copy of the Notice of Privacy Practices.

Signature: _____ **Date:** _____