Patient # (office use only) ________________

Name: ______________________________ Date of Birth: ______________

Address: ______________________________ PO Box: ________ Ethnicity: ______________

City: ______________________________ State: __________ Zip Code: ______________

Home Phone: ______________ Cell Phone: ______________ SSN: ______________

Sex: M F **Marital Status:** Married Single Widow Divorced Other Number of Children: _____

Have you ever been seen by a podiatrist before? ______________________________

Who referred you to us: ______________________________

Responsible party (other than yourself) ______________________________ Relationship: __________

Reason for today's visit: ______________________________

Previous treatment: ______________________________ Injury: ☐ Yes ☐ No

Onset: ☐ Sudden ☐ Gradual ☐ Chronic Duration: ______________________________

Pain level: ☐ Mild ☐ Moderate ☐ Moderate to Severe ☐ Severe

Occupation: ______________________________ ☐ Retired ☐ FT Student ☐ PT Student

Job description: ______________________________

Employer: ______________________________ Work Phone: ______________

Address: ______________________________ ______________________________

How is your general health? ______________________________ Height: __________Weight: __________

CURRENT PROBLEM LIST:

☐ Diabetes (Type 1) ☐ Diabetes (Type 2) ☐ Circulatory condition ☐ Hypertension

REVIEW OF SYSTEMS: Please check all that apply

GENERAL:

- ☐ Change in weight
- ☐ Malaise / Fatigue
- ☐ Recent trauma
- ☐ Recent antibiotics
- ☐ Vit B12 deficiency
- ☐ Regular exercise
- ☐ MRSA
- ☐ Coumadin use
- ☐ Excessive thirst
- ☐ Frequent urination
- ☐ Stomach ulcer
- ☐ Pregnant
- ☐ Birth defects

RESPIRATORY:

- ☐ Difficulty breathing
- ☐ Shortness of breath

MUSCULOSKELETAL:

- ☐ Pain
- ☐ Weakness
- ☐ Joint swelling
- ☐ Leg swelling
- ☐ Degenerative disease
- ☐ Rheumatoid Arthritis
- ☐ Difficulty walking
- ☐ Red joints
- ☐ Low back pain
- ☐ Back pain into legs

NEUROLOGICAL:

- ☐ Numbness
- ☐ Tingling
- ☐ Burning
- ☐ Stroke
- ☐ Sciatica
- ☐ Drop foot
- ☐ Dementia / Alzheimer's

DERMETOLOGICAL:

- ☐ Skin cancer
- ☐ Rash
- ☐ Non-healing lesion
- ☐ Excessive sweating
- ☐ Hair loss

CARDIOVASCULAR:

- ☐ Chest pain
- ☐ Blood thinners
- ☐ Irregular heartbeat
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Leg cramps
- ☐ Stent
- ☐ Valvular disease

OTHER:

- ☐ ______________
- ☐ ______________
- ☐ ______________
- ☐ ______________