

Patient Name: _____ Date: _____

Pharmacy: _____ Telephone Number: _____

Family /Referring Doctor _____ Date Last Seen: _____

History & Medical Information

1. Explain your foot/ankle problem Right Left _____
2. Describe the pain/discomfort: Burning Numbness Sharp Other _____
3. When did the pain/discomfort begin? _____
4. What makes the pain/discomfort better: _____
5. What makes the pain/discomfort worst: _____
6. List all medications/herbs/vitamins: NONE _____
7. Allergies: (Describe reaction) NONE
 - Penicillin _____ Aspirin _____ Narcotic Agent / Codeine _____
 - Anesthesia _____ Shellfish _____ Sulfa Drugs _____
 - Nickel / Metal _____ Radiographic Contrast Dye _____
 - Other _____

8. Past Medical and Family History

Condition	Self	Family	Condition	Self	Family
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anesthetic Reaction	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Nails Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Nerve Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Avg Glucose _____	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Foot Problem(s)	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intest Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Injury Trauma - Major	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>

9. **Surgical History:** Have you had surgery? Yes—if yes, describe below No
Surgery / Date: _____

10. **Social History:** (Only check what is pertinent to you)
 Tobacco Use Alcohol Use Exercise habits _____
 Caffeine Use Drug use (recreational, IV)

11. **Occupation:** _____ **Is your problem work related?** Yes No

12. **Are you currently pregnant?** _____

13. **Height:** _____ **Weight:** _____ **Shoe Size:** _____

Please check any of the following that you are **currently experiencing** or have **recently experienced**.

Constitutional:	Y N	Do you limp when you walk?	<input type="checkbox"/> <input type="checkbox"/>
Generally do you feel well?	<input type="checkbox"/> <input type="checkbox"/>	Do your shoes wear out quickly or unevenly?	<input type="checkbox"/> <input type="checkbox"/>
Do you feel fatigued during the day?	<input type="checkbox"/> <input type="checkbox"/>	Integumentary (Skin):	Y N
Does your problem limit your normal daily activities?	<input type="checkbox"/> <input type="checkbox"/>	Do you have any skin problems?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a fever?	<input type="checkbox"/> <input type="checkbox"/>	Is your skin strongly sensitive when exposed to the sun?	<input type="checkbox"/> <input type="checkbox"/>
yes:	Y N	Do you have any skin rashes?	<input type="checkbox"/> <input type="checkbox"/>
Do you wear glasses or contacts?	<input type="checkbox"/> <input type="checkbox"/>	Do you have any warts on your feet?	<input type="checkbox"/> <input type="checkbox"/>
Do you have burning or itchy eyes?	<input type="checkbox"/> <input type="checkbox"/>	Do you have any moles, lumps, bumps on your skin?	<input type="checkbox"/> <input type="checkbox"/>
Do you have sensitivity to light?	<input type="checkbox"/> <input type="checkbox"/>	Do you have extremely dry skin or cracking?	<input type="checkbox"/> <input type="checkbox"/>
Do you have watering of your eyes?	<input type="checkbox"/> <input type="checkbox"/>	Do you have any open skin sores?	<input type="checkbox"/> <input type="checkbox"/>
Are your eyes frequently red?	<input type="checkbox"/> <input type="checkbox"/>	Are there unusual areas of discoloration on your skin?	<input type="checkbox"/> <input type="checkbox"/>
Do you have eye pain?	<input type="checkbox"/> <input type="checkbox"/>	Do you have any corns or calluses on your feet?	<input type="checkbox"/> <input type="checkbox"/>
Ears, nose, mouth & throat:	Y N	Are your nails unusually thick?	<input type="checkbox"/> <input type="checkbox"/>
Do you have ringing in your ears?	<input type="checkbox"/> <input type="checkbox"/>	Are your nails deformed?	<input type="checkbox"/> <input type="checkbox"/>
Do you get nosebleeds?	<input type="checkbox"/> <input type="checkbox"/>	Are your nails ingrown and tender?	<input type="checkbox"/> <input type="checkbox"/>
Do you have difficulty swallowing?	<input type="checkbox"/> <input type="checkbox"/>	Do your nails cause you pain?	<input type="checkbox"/> <input type="checkbox"/>
Cardiovascular:	Y N	Do you have problems with your fingernails?	<input type="checkbox"/> <input type="checkbox"/>
Have you noticed your legs or ankles swelling?	<input type="checkbox"/> <input type="checkbox"/>	Do you have noticeable hair loss on your legs or feet?	<input type="checkbox"/> <input type="checkbox"/>
Do you have varicose veins?	<input type="checkbox"/> <input type="checkbox"/>	Neurological	Y N
Do you have cramps in your legs at night or at rest?	<input type="checkbox"/> <input type="checkbox"/>	Do you ever feel dizzy?	<input type="checkbox"/> <input type="checkbox"/>
Do you have cramps in your legs when walking?	<input type="checkbox"/> <input type="checkbox"/>	Do you often feel confused or disoriented?	<input type="checkbox"/> <input type="checkbox"/>
Do your feet feel especially cold?	<input type="checkbox"/> <input type="checkbox"/>	Do you have problems with your balance?	<input type="checkbox"/> <input type="checkbox"/>
Respiratory:	Y N	Do you have frequent or reoccurring headaches?	<input type="checkbox"/> <input type="checkbox"/>
Do you have chest pain?	<input type="checkbox"/> <input type="checkbox"/>	Do you have seizures?	<input type="checkbox"/> <input type="checkbox"/>
Do you have difficulty breathing?	<input type="checkbox"/> <input type="checkbox"/>	Do you have tremors of your extremities?	<input type="checkbox"/> <input type="checkbox"/>
Do you have shortness of breath?	<input type="checkbox"/> <input type="checkbox"/>	Do your legs often feel like they "are going to sleep"?	<input type="checkbox"/> <input type="checkbox"/>
Have you had a cough lasting longer than 3 weeks?	<input type="checkbox"/> <input type="checkbox"/>	Do you have numbness in your legs?	<input type="checkbox"/> <input type="checkbox"/>
Gastrointestinal:	Y N	-a feeling of burning in your legs?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a loss of increase in appetite?	<input type="checkbox"/> <input type="checkbox"/>	-cramps or pain in the legs with walking or exercise?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a history of stomach ulcers?	<input type="checkbox"/> <input type="checkbox"/>	-leg pain that is worse at night or at rest?	<input type="checkbox"/> <input type="checkbox"/>
Do you have heartburn?	<input type="checkbox"/> <input type="checkbox"/>	-leg pain all the time?	<input type="checkbox"/> <input type="checkbox"/>
Does Aspirin cause stomach pain?	<input type="checkbox"/> <input type="checkbox"/>	-experience shooting pain down your legs?	<input type="checkbox"/> <input type="checkbox"/>
Do you have bloody or dark stools?	<input type="checkbox"/> <input type="checkbox"/>	-paralysis (complete loss of muscle strength) in legs?	<input type="checkbox"/> <input type="checkbox"/>
Genitourinary:	Y N	Psychiatric:	Y N
Do you urinate more frequently than before?	<input type="checkbox"/> <input type="checkbox"/>	Do you have a history of psychiatric problems?	<input type="checkbox"/> <input type="checkbox"/>
Do you have pain with urination?	<input type="checkbox"/> <input type="checkbox"/>	Are you subject to mood swings?	<input type="checkbox"/> <input type="checkbox"/>
Do you have burning with urination?	<input type="checkbox"/> <input type="checkbox"/>	Are you under a lot of stress?	<input type="checkbox"/> <input type="checkbox"/>
Have you noticed blood in your urine?	<input type="checkbox"/> <input type="checkbox"/>	Endocrine:	Y N
Musculoskeletal:	Y N	Do you urinate more frequently than before?	<input type="checkbox"/> <input type="checkbox"/>
Do you have low back pain?	<input type="checkbox"/> <input type="checkbox"/>	Are you excessively thirsty?	<input type="checkbox"/> <input type="checkbox"/>
Do you have pain in your legs?	<input type="checkbox"/> <input type="checkbox"/>	Do you have a history of bad breath?	<input type="checkbox"/> <input type="checkbox"/>
Do you have foot pain?	<input type="checkbox"/> <input type="checkbox"/>	Are you experiencing night sweats?	<input type="checkbox"/> <input type="checkbox"/>
Do you have joint pain?	<input type="checkbox"/> <input type="checkbox"/>	Do you have swollen glands?	<input type="checkbox"/> <input type="checkbox"/>
Do you have bone pain?	<input type="checkbox"/> <input type="checkbox"/>	Have you had a significant weight change recently?	<input type="checkbox"/> <input type="checkbox"/>
Do you have general muscle aches or pains?	<input type="checkbox"/> <input type="checkbox"/>	Hematologic / Lymphatic	Y N
Have you had swelling in your legs?	<input type="checkbox"/> <input type="checkbox"/>	Do you bruise easily?	<input type="checkbox"/> <input type="checkbox"/>
Have you had joint swelling or stiffness?	<input type="checkbox"/> <input type="checkbox"/>	Allergic / Immunologic:	Y N
Have you noticed a change in the way you walk?	<input type="checkbox"/> <input type="checkbox"/>	If you get cut, does it take a long time to heal?	<input type="checkbox"/> <input type="checkbox"/>
Is it difficult to climb stairs?	<input type="checkbox"/> <input type="checkbox"/>	Do you have allergic reactions to medication, foods dye?	<input type="checkbox"/> <input type="checkbox"/>
Are you experiencing a loss of strength in your legs?	<input type="checkbox"/> <input type="checkbox"/>		
Have you felt rigidity in your legs?	<input type="checkbox"/> <input type="checkbox"/>		