DR RICHARD GALPERIN
A Division of Podiatric Medical Partners of Texas

Patient Name____**Date**____________________

History & Medical Information

Explain your foot/ankle problem(Right) (Left)____

____

Describe the pain/discomfort: (burning) (Sharp) (numbness) Other:__________________________

When did the pain/discomfort start?____

What makes the pain/discomfort better?____

What makes the pain/discomfort worse?____

List all medications/herbs/vitamins:____

____

Allergies:____

Surgical History : Have you had surgery? If yes describe below

Type of surgery and Date:____

____

Alcohol Use: (yes) (no)

Tobacco Use: (yes) (no)

Drug Use: (yes) (no)

Caffeine Use: (yes) (no)