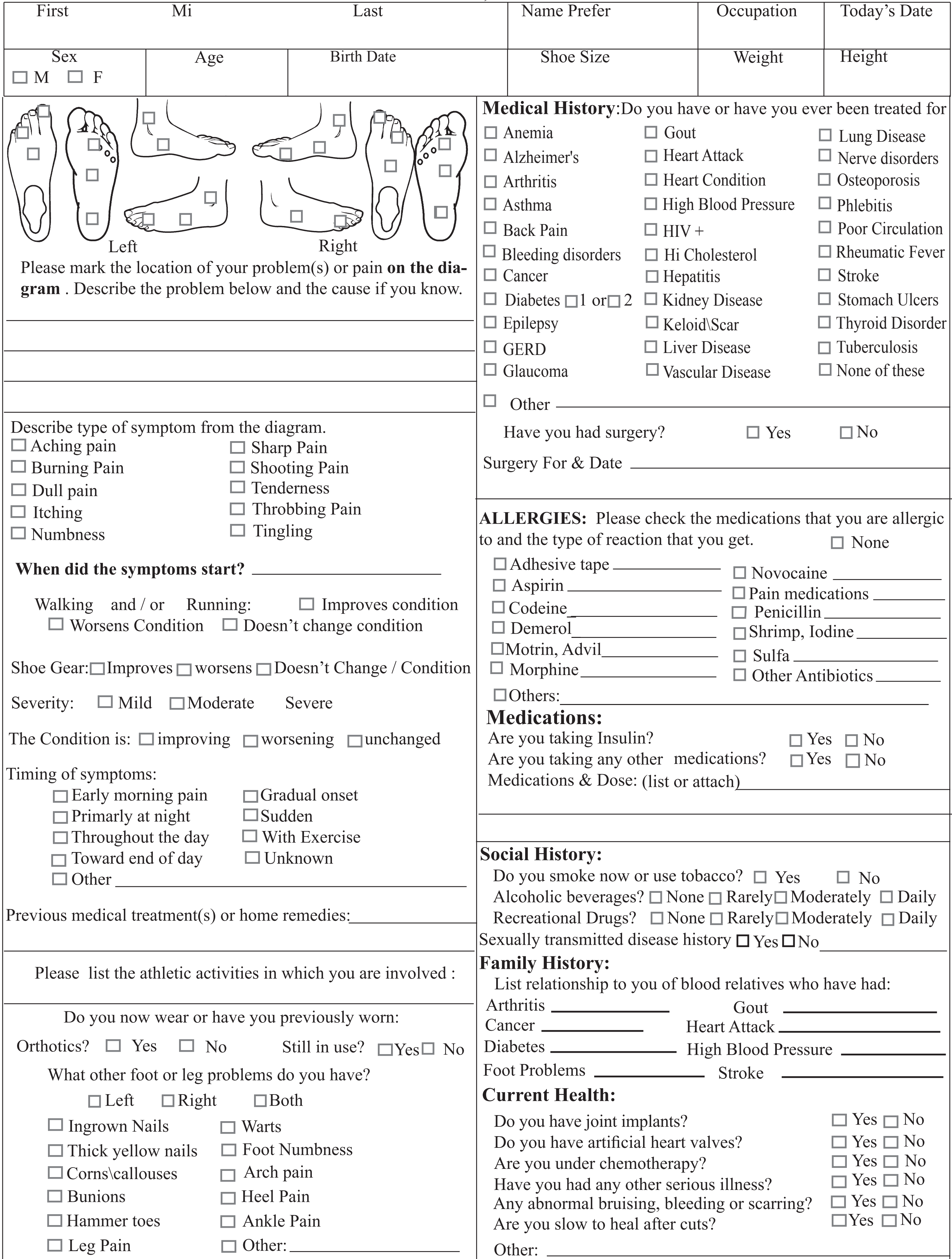
NORTHSIDE PODIATRY PC, PATIENT INFORMATION



First	Mi	Last	Name Prefer	Occupation	Today's Date

Sex ☐ M ☐ F	Age	Birth Date	Shoe Size	Weight	Height

Please mark the location of your problem(s) or pain **on the diagram** . Describe the problem below and the cause if you know.

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Describe type of symptom from the diagram.

☐ Aching pain ☐ Sharp Pain
☐ Burning Pain ☐ Shooting Pain
☐ Dull pain ☐ Tenderness
☐ Itching ☐ Throbbing Pain
☐ Numbness ☐ Tingling

When did the symptoms start? ______________________

Walking and / or Running: ☐ Improves condition ☐ Worsens Condition ☐ Doesn't change condition

Shoe Gear: ☐ Improves ☐ worsens ☐ Doesn't Change / Condition

Severity: ☐ Mild ☐ Moderate Severe

The Condition is: ☐ improving ☐ worsening ☐ unchanged

Timing of symptoms:

☐ Early morning pain ☐ Gradual onset
☐ Primarily at night ☐ Sudden
☐ Throughout the day ☐ With Exercise
☐ Toward end of day ☐ Unknown
☐ Other ______________________

Previous medical treatment(s) or home remedies: ______________________

Please list the athletic activities in which you are involved :

Do you now wear or have you previously worn:

Orthotics? ☐ Yes ☐ No Still in use? ☐ Yes ☐ No

What other foot or leg problems do you have?

☐ Left ☐ Right ☐ Both

☐ Ingrown Nails ☐ Warts
☐ Thick yellow nails ☐ Foot Numbness
☐ Corns\callouses ☐ Arch pain
☐ Bunions ☐ Heel Pain
☐ Hammer toes ☐ Ankle Pain
☐ Leg Pain ☐ Other: ______________________

Medical History: Do you have or have you ever been treated for

☐ Anemia ☐ Gout ☐ Lung Disease
☐ Alzheimer's ☐ Heart Attack ☐ Nerve disorders
☐ Arthritis ☐ Heart Condition ☐ Osteoporosis
☐ Asthma ☐ High Blood Pressure ☐ Phlebitis
☐ Back Pain ☐ HIV + ☐ Poor Circulation
☐ Bleeding disorders ☐ Hi Cholesterol ☐ Rheumatic Fever
☐ Cancer ☐ Hepatitis ☐ Stroke
☐ Diabetes ☐ 1 or ☐ 2 ☐ Kidney Disease ☐ Stomach Ulcers
☐ Epilepsy ☐ Keloid\Scar ☐ Thyroid Disorder
☐ GERD ☐ Liver Disease ☐ Tuberculosis
☐ Glaucoma ☐ Vascular Disease ☐ None of these

☐ Other ______________________

Have you had surgery? ☐ Yes ☐ No

Surgery For & Date ______________________

ALLERGIES: Please check the medications that you are allergic to and the type of reaction that you get. ☐ None

☐ Adhesive tape ____________ ☐ Novocaine ____________
☐ Aspirin ____________ ☐ Pain medications ____________
☐ Codeine ____________ ☐ Penicillin ____________
☐ Demerol ____________ ☐ Shrimp, Iodine ____________
☐ Motrin, Advil ____________ ☐ Sulfa ____________
☐ Morphine ____________ ☐ Other Antibiotics ____________
☐ Others: ______________________

Medications:

Are you taking Insulin? ☐ Yes ☐ No
Are you taking any other medications? ☐ Yes ☐ No
Medications & Dose: (list or attach) ______________________

Social History:

Do you smoke now or use tobacco? ☐ Yes ☐ No
Alcoholic beverages? ☐ None ☐ Rarely ☐ Moderately ☐ Daily
Recreational Drugs? ☐ None ☐ Rarely ☐ Moderately ☐ Daily
Sexually transmitted disease history ☐ Yes ☐ No ____________

Family History:

List relationship to you of blood relatives who have had:

Arthritis ____________ Gout ____________
Cancer ____________ Heart Attack ____________
Diabetes ____________ High Blood Pressure ____________
Foot Problems ____________ Stroke ____________

Current Health:

Do you have joint implants? ☐ Yes ☐ No
Do you have artificial heart valves? ☐ Yes ☐ No
Are you under chemotherapy? ☐ Yes ☐ No
Have you had any other serious illness? ☐ Yes ☐ No
Any abnormal bruising, bleeding or scarring? ☐ Yes ☐ No
Are you slow to heal after cuts? ☐ Yes ☐ No

Other: ______________________