HISTORY AND PHYSICAL

PRIMARY CARE PHYSICIAN: _____ DATE: _____

HOME
NAME: _____AGE: _____ PHONE: _____HEIGHT: _____ WEIGHT:_____
CELL
PHONE: _____E-MAIL:_____ B/P: _____/_____PULSE: _____BMI: _____

CHIEF COMPLAINT: _____

_____

SUBJECTIVE SIGNS AND SYMPTONS: _____

_____

PREVIOUS TREATMENT: _____

_____

OTHER PODIATRIC PROBLEMS: _____
☐BUNIONS ☐CORNS ☐CALLUSES ☐INGROWN NAILS ☐HEEL PAIN ☐ARCH PAIN ☐ANKLE PAIN ☐METATARSALGIA

HOME TREATMENT FOR THIS CONDITION: _____

HAVE YOU PERSONALLY EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS?
☐CHEST PAIN ☐ASTHMA ☐KIDNEY PROB ☐ANEMIA ☐LIVER DISEASE ☐BLEEDING PROB ☐FOOT ULCERS
☐HEART PROB ☐ARTHRITIS ☐BLOOD CLOTS ☐STROKE ☐NEUROPATHY ☐HIGH CHOLESTEROL ☐GOUT
☐SICKLE CELL ☐DIABETES ☐THYROID PROB ☐CANCER ☐STOMACH ULCERS ☐HIGH BLOOD PRESSURE ☐HIV

OTHER: _____
☐ **I** AM NOT CURRENTLY BEING TREATED FOR ANY CONDITIONS.

HAS ANYONE IN YOUR IMMEDIATE FAMILY EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS?
☐CHEST PAIN ☐ASTHMA ☐KIDNEY PROB ☐ANEMIA ☐LIVER DISEASE ☐BLEEDING PROB ☐FOOT ULCERS
☐HEART PROB ☐ARTHRITIS ☐BLOOD CLOTS ☐STROKE ☐NEUROPATHY ☐HIGH CHOLESTEROL ☐GOUT
☐SICKLE CELL ☐DIABETES ☐THYROID PROB ☐CANCER ☐STOMACH ULCERS ☐HIGH BLOOD PRESSURE ☐HIV
OTHER: _____ ☐ADOPTED
☐**N**O ONE IN MY IMMEDIATE FAMILY HAS EVER BEEN TREATED FOR ANY OF THE ABOVE CONDITIONS.

PREVIOUS SURGERIES: _____

_____
ALCOHOL: _____ NONE SOCIAL MODERATE HEAVY TOBACCO: CIG/DAY _____ HOW LONG? _____ ARE YOU PREGNANT? _____

CURRENT MEDICATIONS: _____

_____

ALLERGIES: ☐**I** HAVE NO ALLERGIES.
☐**I** AM ALLERGIC TO THE FOLLOWING:
☐TYLENOL ☐TAPE ☐ASPIRIN ☐KEFLEX ☐CODEINE ☐LATEX ☐IODINE
☐PENICILLIN ☐SULFA ☐MOTRIN ☐DARVON ☐NOVOCAINE ☐DEMEROL ☐SHELL FISH
☐OTHER: _____