

HISTORY AND PHYSICAL

PLEASE FILL OUT SHADED AREAS ONLY!

DATE: _____

NAME: _____ AGE: _____ PHONE: _____ HEIGHT: _____ WEIGHT: _____

CHIEF COMPLAINT: _____

SUBJECTIVE SIGNS AND SYMPTOMS: _____

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

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

OTHER: _____ ADOPTED

NO 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 ASA KEFLEX CODIENE LATEX ODINE
 PENICILLIN SULFA MORTIN DARVON NOVOCAINE DEMEROL SHELL FISH
 OTHER: _____

OVER