HISTORY AND PHYSICAL

PLEASE FILL OUT SHADED AREAS ONLY! DATE: _____

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

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

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 ☐IODINE
☐PENICILLIN ☐SULFA ☐MORTIN ☐DARVON ☐NOVOCAINE ☐DEMEROL ☐SHELL FISH
☐OTHER: _____

OVER