Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT MEDICAL HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Bunion** | **Hammertoe** | **Heel Pain** | **Plantar Fasciitis** | **Nail Fungus** |
| **Location: LEFT or RIGHT** | **Location: LEFT or RIGHT** | **Location: LEFT or RIGHT** | **Location: LEFT or RIGHT** | **Location: LEFT or RIGHT** |
| □ Top□ Bottom□ Inside□ Outside□ Toes | □ Top□ Bottom□ Inside□ Outside□ Toes | □ Top□ Bottom□ Inside□ Outside□ Toes | □ Top□ Bottom□ Inside□ Outside□ Toes | □ Top□ Bottom□ Inside□ Outside□ Toes□ Nails |
| **Describe the pain:** | **Describe the pain:** | **Describe the pain:** | **Describe the pain:** | **Describe the pain:** |
| □ Sharp□ Dull□ Throbbing□ Burning□ Radiating□ Numbness | □ Sharp□ Dull□ Throbbing□ Burning□ Radiating□ Numbness | □ Sharp□ Dull□ Throbbing□ Burning□ Radiating□ Numbness | □ Sharp□ Dull□ Throbbing□ Burning□ Radiating□ Numbness | □ Sharp□ Dull□ Throbbing□ Burning□ Radiating□ Numbness |
| **How long has this been a concern?** | **How long has this been a concern?** | **How long has this been a concern?** | **How long has this been a concern?** | **How long has this been a concern?** |
| □ \_\_\_\_\_ Days□ \_\_\_\_\_ Weeks□ \_\_\_\_\_ Months□ \_\_\_\_\_ Years | □ \_\_\_\_\_ Days□ \_\_\_\_\_ Weeks□ \_\_\_\_\_ Months□ \_\_\_\_\_ Years | □ \_\_\_\_\_ Days□ \_\_\_\_\_ Weeks□ \_\_\_\_\_ Months□ \_\_\_\_\_ Years | □ \_\_\_\_\_ Days□ \_\_\_\_\_ Weeks□ \_\_\_\_\_ Months□ \_\_\_\_\_ Years | □ \_\_\_\_\_ Days□ \_\_\_\_\_ Weeks□ \_\_\_\_\_ Months□ \_\_\_\_\_ Years |
| **Pain scale:** | **Pain scale:** | **Pain scale:** | **Pain scale:** | **Pain scale:** |
| □ 0 – no pain□ 2 –mild pain□ 4 – moderate pain□ 6 – severe pain□ 8 – very severe pain□ 10- worst possible pain | □ 0 – no pain□ 2 –mild pain□ 4 – moderate pain□ 6 – severe pain□ 8 – very severe pain□ 10- worst possible pain | □ 0 – no pain□ 2 –mild pain□ 4 – moderate pain□ 6 – severe pain□ 8 – very severe pain□ 10- worst possible pain | □ 0 – no pain□ 2 –mild pain□ 4 – moderate pain□ 6 – severe pain□ 8 – very severe pain□ 10- worst possible pain | □ 0 – no pain□ 2 –mild pain□ 4 – moderate pain□ 6 – severe pain□ 8 – very severe pain□ 10- worst possible pain |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Corn/callus** | **Foot/ankle injury** | **Ingrown toenail** | **Neuroma** | **Plantar warts** |
| **Location: LEFT or RIGHT** | **Location: LEFT or RIGHT** | **Location: LEFT or RIGHT** | **Location: LEFT or RIGHT** | **Location: LEFT or RIGHT** |
| □ Top□ Bottom□ Inside□ Outside□ Toes□ Nails | □ Top□ Bottom□ Inside□ Outside□ Toes□ Nails | □ Top□ Bottom□ Inside□ Outside□ Toes□ Nails | □ Top□ Bottom□ Inside□ Outside□ Toes□ Nails | □ Top□ Bottom□ Inside□ Outside□ Toes |
| **Describe the pain:** | **Describe the pain:** | **Describe the pain:** | **Describe the pain:** | **Describe the pain:** |
| □ Sharp□ Dull□ Throbbing□ Burning□ Radiating□ Numbness | □ Sharp□ Dull□ Throbbing□ Burning□ Radiating□ Numbness | □ Sharp□ Dull□ Throbbing□ Burning□ Radiating□ Numbness | □ Sharp□ Dull□ Throbbing□ Burning□ Radiating□ Numbness | □ Sharp□ Dull□ Throbbing□ Burning□ Radiating□ Numbness |
| **How long has this been a concern?** | **How long has this been a concern?** | **How long has this been a concern?** | **How long has this been a concern?** | **How long has this been a concern?** |
| □ \_\_\_\_\_ Days□ \_\_\_\_\_ Weeks□ \_\_\_\_\_ Months□ \_\_\_\_\_ Years | □ \_\_\_\_\_ Days□ \_\_\_\_\_ Weeks□ \_\_\_\_\_ Months□ \_\_\_\_\_ Years | □ \_\_\_\_\_ Days□ \_\_\_\_\_ Weeks□ \_\_\_\_\_ Months□ \_\_\_\_\_ Years | □ \_\_\_\_\_ Days□ \_\_\_\_\_ Weeks□ \_\_\_\_\_ Months□ \_\_\_\_\_ Years | □ \_\_\_\_\_ Days□ \_\_\_\_\_ Weeks□ \_\_\_\_\_ Months□ \_\_\_\_\_ Years |
| **Pain scale:** | **Pain scale:** | **Pain scale:** | **Pain scale:** | **Pain scale:** |
| □ 0 – no pain□ 2 –mild pain□ 4 – moderate pain□ 6 – severe pain□ 8 – very severe pain□ 10- worst possible pain**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | □ 0 – no pain□ 2 –mild pain□ 4 – moderate pain□ 6 – severe pain□ 8 – very severe pain□ 10- worst possible pain | □ 0 – no pain□ 2 –mild pain□ 4 – moderate pain□ 6 – severe pain□ 8 – very severe pain□ 10- worst possible pain | □ 0 – no pain□ 2 –mild pain□ 4 – moderate pain□ 6 – severe pain□ 8 – very severe pain□ 10- worst possible pain | □ 0 – no pain□ 2 –mild pain□ 4 – moderate pain□ 6 – severe pain□ 8 – very severe pain□ 10- worst possible pain |

**PATIENT MEDICAL HISTORY**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shoe size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUIRED FOR CONSULTATION**

**WHAT AGGRIVATES THE PAIN?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHAT RELEIVES THE PAIN?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What conservative methods have you tried?**

**(For a minimum of 12 weeks)**

□ Rest

□ Ice/heat

□ Wide shoes/ shoe modification/inserts/ toe pads/ spacers/ bunion pad

□ Foot soaks

□ Pain relievers

□ Steroid shots

□ Physical therapy

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

 □ Codeine □ Penicillin □ Keflex □ Aspirin □ Sulfa □ Lidocaine □ Neosporin □ Adhesive tape □ Iodine

 □ Foods\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□ NO KNOWN ALLERGY**

**PHARMACY**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City / State \_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY PHYSICIAN**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City / State \_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY** **DO YOU SMOKE? \_\_\_\_\_\_\_\_ DO YOU DRINK? \_\_\_\_\_\_\_\_**

 **YOU FAMILY YOU FAMILY YOU FAMILY**

Alcoholism \_\_\_\_\_ \_\_\_\_\_ High Cholesterol \_\_\_\_\_ \_\_\_\_\_ Poor Circulation \_\_\_\_\_ \_\_\_\_\_

Arthritis \_\_\_\_\_ \_\_\_\_\_ HIV/AIDS \_\_\_\_\_ \_\_\_\_\_ Rheumatoid Arthritis \_\_\_\_\_ \_\_\_\_\_

Blood Clots \_\_\_\_\_ \_\_\_\_\_ Hypertension \_\_\_\_\_ \_\_\_\_\_ Seizures \_\_\_\_\_ \_\_\_\_\_

Cancer \_\_\_\_\_ \_\_\_\_\_ Kidney Disease \_\_\_\_\_ \_\_\_\_\_ Stroke \_\_\_\_\_ \_\_\_\_\_

COPD/Asthma \_\_\_\_\_ \_\_\_\_\_ Liver Disease/Hepatitis \_\_\_\_\_ \_\_\_\_\_ Thyroid Disease \_\_\_\_\_ \_\_\_\_\_

Diabetes \_\_\_\_\_ \_\_\_\_\_ Mental Health Concerns \_\_\_\_\_ \_\_\_\_\_ Tobacco Use \_\_\_\_\_ \_\_\_\_\_

Epilepsy \_\_\_\_\_ \_\_\_\_\_ Migraines \_\_\_\_\_ \_\_\_\_\_ Tuberculosis \_\_\_\_\_ \_\_\_\_\_

Fibromyalgia \_\_\_\_\_ \_\_\_\_\_ MRSA/VRSA \_\_\_\_\_ \_\_\_\_\_ Varicose veins \_\_\_\_\_ \_\_\_\_\_

Gout \_\_\_\_\_ \_\_\_\_\_ Multiple Sclerosis \_\_\_\_\_ \_\_\_\_\_ VRE \_\_\_\_\_ \_\_\_\_\_

Heart Attack \_\_\_\_\_ \_\_\_\_\_ Nerve problems \_\_\_\_\_ \_\_\_\_\_ Other \_\_\_\_\_ \_\_\_\_\_

Heart Disease \_\_\_\_\_ \_\_\_\_\_ Pacemaker/Defibrillator \_\_\_\_\_ \_\_\_\_\_

**For each checked above explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List any other medical conditions not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past Surgical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**