**PATIENT MEDICAL HISTORY**

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

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

**PRIMARY CONCERN** □ left □ right □ both

□ Nail fungus □ Plantar fasciitis □ Heel pain

□ Ingrown toenail □ Foot/ankle injury □ Bunion

□ Neuroma □ Plantar warts □ Hammertoe

□ Work related injury □ Corn/callus □ 2nd opinion □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DESCRIBE THE PAIN**

□ Sharp □ dull □ throbbing □ burning

□ radiating □ numbness

**LOCATION**

□ top □ bottom □ inside □ outside

□ toes □ webs □ nails

**HOW LONG HAS THIS BEEN A CONCERN**

□ days □ week’s □ month’s □ years

How Many? \_\_\_\_\_\_\_\_\_

**What conservative methods have you tried?**

□ Rest

□ Ice/heat

□ Shoe modification/inserts

□ Wide shoes

□ Toe pads/spacers

□ Foot soaks

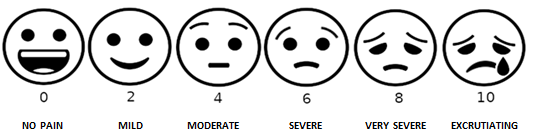
□ Pain relievers

□ Steroid shots

□ Physical therapy

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

**PAIN SCALE** – circle one



**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**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**