Feet First Podiatry - Patient History & Physical

Patient Name: _____ Date of Birth: _____

History of:	Self	Blood Relative - Specify Who: Mother	Father	Sibling	Grandparent	Other	Additional Details on Condition or Disease
Alcoholism							
Alzheimer's/Dementia							
Anxiety Disorder or Depression							
Arthritis (List type: Osteo or Rhumatoid)							
Asthma or Breathing Issues (Specify)							
Blood Clot or Deep Vein Thrombosis							
Blood Disorders (Specify)							
Cancer (Specify)							
Circulation Problems (Specify)							
CVA (or Stroke)							
Diabetes (List Type I or Type II)							
Emphysema or COPD (Specify)							
Eye Disease (Cataracts, Glaucoma, etc)							
Gout							
Heart Disease or Condition (Specify)							
Hepatitis							
High Blood Pressure							
High Cholesterol							
HIV							
Kidney Disease							
Liver Disease (Specify)							
Mental Illness							
Musculoskeletal Disorders							
Neurological Disorders (Specify)							
Neuropathy (Specify where)							
Skin Disorders							
Sleep Apnea							
Stomach or Bowel Problems							
Thyroid Disease (Specify Type)							
Other (Specify)							

Weight:_____ Height:_____ Blood Pressure: _____/_____ Are you pregnant? Yes No Are you nursing? Yes No

Surgical History: ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
☐ Other (Please List):_____

Have you ever had any surgical procedures on your foot or ankle? ☐ Yes ☐ No If Yes, please describe: _____
_____

Do you have any artificial joints? ☐ Yes Where?_____ ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

List Allergies:							
List Reactions:							

List Medications:							
List Doses:							

Do you get an annual flu shot? _____ Yes _____ No Do you get a pneumonia shot? _____ Yes _____ No

Social History: Do you smoke? Yes No How many packs/day?_____ How long have you smoked? _____
Are you a former smoker? Yes No When did you quit? _____
Do you drink alcohol? ☐ Yes, everyday (5-7 days/wk) ☐ Yes, occasionally/socially ☐ No, rarely
Substance Abuse: _____ Yes, I have a current substance abuse problem (please specify):_____
_____ Yes, I had a past problem (please specify):_____ . _____No, I never had a problem

What is your occupation?_____ Does it involve mostly ☐ Standing ☐ Sitting
Do you exercise regularly? _____ No, I do not exercise regularly _____ Yes, I do the following: _____
_____

Signature: X_____ Date: _____