PATIENT RECORD (2009) TODAYS DATE_____

Account #_____ **Please fill out completely** Location: PG 1

Dr. _____

Patients full name:

Last_____First_____MI_____ Sex M F

Patient SS #_____ Date of Birth_____

Marital Status S M D W Name of Spouse _____

Phone_____Work_____Cel _____

Local Address_____

City_____ State_____ Zip_____

Second or out of state Address_____

City_____State_____Zip_____

Pharmacy # _____ E-Mail _____

Employer Name _____ Job Title _____

Company Phone _____ Address _____

_____

How did you hear about us?_____ If referred, by whom?_____

Name and **relationship** of Emergency Contact _____

Phone number of Emergency Contact _____

Name of Family Physician_____ Date last seen: _____

Phone_____ Fax_____

Address_____

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

Person responsible for services rendered if different than listed above

Name_____ SS#_____

Address_____

Phone_____ DOB _____

Please describe what brings you to the office today?

_____

_____

How would you describe your pain?

Sharp aching throbbing Shooting
electrical sensation pins and needles burning

Location of pain or primary complaint:

lower leg ankle Achilles tendon heel midfoot arch forefoot
sole of foot ball of foot top of foot big toe lesser toes toenails

How long has your problems been present?

1 – 3 days 3 – 7 days 1 – 3 weeks 3 – 6 weeks 6 – 8 weeks
3 – 6 months 6 – 9 months 9 – 12 months greater than 1 year

Onset of condition or injury:

gradual onset over time sudden onset from activity or injury

Course/progression of condition:

severe worsening moderate worsening mild worsening steady / unchanging
mild improvement moderate improvement considerable/good improvement

Pain / condition aggravated by:

any weight bearing standing walking running exercise bending
stooping pressure to ball of foot pressure from shoes pressure from jumping

Have you attempted any treatments to relieve your problem?

rest ice elevation change shoe gear over the counter padding
over the counter anti-inflammatory medication (Motrin, Aleve, Tylenol, Aspirin, etc)
in home whirlpool stretching trimming out toenail yourself applying skin cream
applying topical antibiotic ointment (triple antibiotic, bacitracin, Neosporin, ext)

How much improvement and relief have you achieved with previous treatments?

mild improvement moderate improvement considerable improvement
no improvement worsening of condition

What is your activity level at work:

sitting standing walking considerable movement/walking retired

Name of Primary Care / Family Physician (first and last name) ?

_____

Date last seen by Primary Care / Family Physician (month, day and year if known)

How did you hear about our office ?

physician family/friend internet newspaper

phone book advertisement other _____

Past medical history:

hypertention/high blood pressure HIV/AIDS hepatitis heart attack/MI insulin dependent diabetes

non insulin dependent diabetes stroke/CVA aneurysm blood clot

Do you have:

fatigue nausea chills

weight loss greater than 10 pounds weight gain greater than 10 pounds

Eyes - Do you have:

impaired vision cataracts glaucoma

macular degeneration frequent eye infections

Ears - Do you have:

hearing loss frequent ear infections

dizziness loss of balance

Nose - Do you have:

sinus problems/Allergies frequent nose bleeds difficulty breathing

nasal polyps deviated septum

Throat - Do you have:

frequent throat infections hoarseness

difficulties with speech frequent swollen nodes/glands in neck

Respiratory - Do you have:

asthma bronchitis emphysema shortness of breath tuberculosis valley fever
lung cancer collapsed lung/atelectasis pneumonia

Cardiovascular - Do you have:

Hypertension/high blood pressure Myocardial Infarct/Heart attack chest pain angina
palpitations/irregular beats valve prolapse/heart murmur rheumatic fever
angioplasty open heart/bypass surgery pacemaker congestive heart failure

Vascular/Circulation - Do you have?

circulation disorder/decrease leg pain at rest leg pain with walking atherosclerosis/blocked arteries
high cholesterol phlebitis blood clot/deep vein thrombosis varicose veins

Gastrointestinal - Do you have:

reflux/heart burn ulcer abdominal pain gallbladder problems liver disorder
hepatitis A hepatitis B hepatitis C
excessive hunger excessive thirst loss of appetite colitis

Genitourinary - Do you have:

frequent bladder/urinary tract infections kidney stone frequent urination/incontinence
renal failure renal dialysis Ovarian cancer (female only) Prostate cancer (male only)

Genitourinary - Have you had any of the following Sexually Transmitted Diseases?

gonorrhea syphilis Chlamydia herpes HIV

Hematological -Do you have:

Anemia sickle cell disease or trait cancer/leukemia blood transfusion

Hematological - Have you been anticoagulant with any of the following blood thinners?

Coumadin Heparin Aspirin Plavix

Endocrine - Do you have:

Diabetes
Thyroid disease

Neurological - Do you have:

seizures stroke tremor change in memory frequent head aches frequent head aches
polio muscle weakness neuro-muscular disease numbness sciatica

Musculoskeletal - Do you have:

Arthritis/degenerative joint disease rheumatoid arthritis gout back pain
hip pain knee pain frequent muscle/tendon pain

Musculoskeletal - Do you have any of the following joint replacements/prosthesis:

hip knee ankle
hands feet spine

Date of joint replacement:

_____

Integument - Do you have:

skin rashes psoriasis eczema skin cancer hives skin growth
color change to mole or wart change in size of skin growth itching to skin thick scar/keloid

Psychiatric - Do you have:

depression nervousness anxious/OCD phobias bipolar disease memory loss
concentration difficulties/ADHD feelings of worthlessness/low self esteem suicidal schizophrenia/psychosis

Immunology - Do you have:

HIV Frequent infections/weak immune system chronic fatigue syndrome/Ebstein Barr

Past medical history – injuries/trauma

_____

Have you had any of the following foot surgeries:

toenail bunion hammertoe fracture repair joint fusions
tendon repair/rerouting ankle stabilization arthroscopy fasciotomy

Please list approximate month and year of any surgery listed above:

_____

Past Surgical History: Have you had any of the following surgeries?

heart bypass heart valve repair/replacement appendectomy

gallbladder brain surgery other

Please list approximate month and year of any surgery listed above:

_____

Any other surgeries? (Please specify type of surgery and date)

_____

Any complications/problems with surgery or anesthetics? (please specify)

_____

Previous hospitalization - have you been admitted for:

heart attack stroke pneumonia cancer

infection injury other hospitalizations

Please list approximate month and year of any hospitalization listed above:

_____

Childhood History - Do you ever had:

rheumatic fever measles mumps chickenpox herpes/cold sores

Childhood Immunizations – have you been immunized for:

measles mumps rubella diphtheria tetanus

varicella zoster polio tuberculosis pneumonia flu

Family History - Father - Does/Did your father have:

Hypertension/high blood pressure CVA/stroke Diabetes

cancer circulation problems

Any other illnesses? (please list) _____

Is your father deceased? yes no

If your father is deceased - age and cause of death_____

Family History - Mother - Does/did your Mother have:

Hypertension/high blood pressure CVA/stroke cancer

circulation problems Diabetes

Any other illnesses? (please list) _____

Is your mother deceased? yes no

If your mother is deceased - age and cause of death _____

Family History Siblings - Does/Did your siblings have:

Hypertension/high blood pressure CVA/stroke cancer

circulation problems Diabetes

Any other illnesses? (please list) _____

Current Occupation: _____

Marital status/ Living arrangement:

married single widowed divorced other

Social History - Do you:

smoke tobacco smoke marijuana use hallucinogenic drugs

drink alcohol use cocaine use other recreational drugs

Number of drinks per day?

1 2 3 4 5 greater than 5 per day 1 – 3/week 4 – 6 /week

Occasional use only social drinking only weekend drinking only

If you smoke, number of packs per day?

1/2 1 2 3 4 5 or more

1 -2/week 3 – 4/week occasional social weekends

If you use other recreational drugs - please list/specify:

_____

Women - Are you pregnant?

yes no

If pregnant, number of months:

_____

Education:

did not complete high school complete high school some college completed college

some grad school masters degree doctorate degree

Medications - please list medications (including aspirin) currently taking:

_____

_____

_____

Allergies - Do you have allergies to any of the following:

drug allergies penicillin sulfa erythromycin

aspirin cortisone codeine adhesive tape

local anesthetics **no known allergies**

Other allergies to medications - please list:

_____

Do you have any **food** allergies - if so, please list:

_____

Do you have any allergies to **plants** - if so, please list:

_____

What is your height? **What** is your weight? **What** is your Shoe size?

_____ _____ _____

~~**Vitals** - What is your Pulse rate per minute? (only if you know your average value - otherwise leave blank)~~

~~**Vitals** - What is your Respiratory rate per minute? (only if you know your average value - otherwise leave blank)~~