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PATIENT HEALTH INFORMATION FORM

Patients Name:_____

Please list all medications you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements. If you have a recently updated list, please provide it to us):

Name Dose How often do you take them?

_____

_____

_____

_____

SOCIAL HISTORY

Employer: _____ **Occupation:** _____

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others depend upon you for their care?

☐ Children ☐ Pet(s) ☐ Elderly or disabled family member ☐ Other

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ weekly ☐ Several times a week ☐ Daily

Types of exercise: _____

Use of Alcohol: ☐ Never ☐ No longer use ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke ____ packs/day for ____ years

Use of Recreational Drugs: ☐ Never ☐ Quit ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

ALLERGIES

Have you ever experienced any adverse side effects or allergies to:

☐Penicillin	☐Novocaine	☐Sulfa Drugs	☐Cortisone
☐Tape	☐Aspirin	☐Iodine	☐Codeine
☐Anti-Inflammatory Meds	☐Other Antibiotics	☐Other Pain Meds	☐Anesthesia
☐Tape	☐Latex	☐ Foods _____	☐ Other _____

Please indicate any of the following that pertain to your medical history:

☐Ankle Swelling	☐Anemia	☐Arthritis RA__ OA__	☐Asthma	☐Abnormal Bleeding
☐Acid Reflux	☐Back trouble	☐Bladder infections	☐Blood Clots	☐Blood Transfusion
☐Bronchitis/ Emphysema	☐Cancer	☐Difficulty hearing	☐Epilepsy	☐Fibromyaglia
☐Gout	☐Heart Attack	☐Heart Disease/ Failure	☐Hepatitis	☐High blood pressure
☐High cholesterol	☐HIV/AIDS	☐Kidney disorder	☐Liver Disorder	☐Low Blood Pressure
☐Lung disorder	☐Migraines	☐Mitral Valve Prolapse	☐Neuropathy	☐Open Sores
☐Pneumonia	☐Polio	☐Poor circulation	☐Rheumatic Fever	☐Shortness of breath
☐Sickle Cell	☐Skin Disorder	☐Sleep Apnea	☐Stomach Ulcers	☐Stroke (date_____)
☐Thyroid Problems		☐Tuberculosis		

Are you currently pregnant? ☐Yes ☐ No

Please see reverse side →

What specific problem brings you to the doctor today?_____

_____

_____

_____

What do you feel may have contributed to your foot/ankle/leg pain?_____

_____

_____

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

Since the time your pain or problem began, has it: ☐ stayed the same ☐ become worse ☐ Improved

What makes your pain or problem feel worse?

☐ Walking ☐ Standing ☐ Daily activities ☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes

☐ Any closed toe shoe ☐ Running ☐ Other _____

What makes your pain or problem feel better? _____

How have you treated your problem so far? _____

Have you seen another doctor for this problem? □ Yes □ No If yes, who? _____

Was this problem caused by an accident? □ No □ Yes If yes, when: _____

Was this a work related injury? □ Yes □ No If yes, where? _____

contact person/supervisor who witnessed/ is aware of the accident:_____case #:_____

If you are a <u>DIABETIC</u> please answer the following questions to the best of your ability:

Are you insulin dependent? □Yes □ No

What was your fasting blood sugar level this morning?_____

What is your average blood sugar level:

☐ 70- 100 mg/ dL ☐ 100- 120 mg/ dL ☐ 120- 140 mg/ dL ☐ 150 and above mg/ dL

What was your recent Hb/ A1C level?_____

Are you aware of the Therapeutic shoe program sponsored by Medicare and most private insurance companies? □ Yes □ No

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

PATIENTS SIGNATURE DATE

_____ _____

PHYSICIANS SIGNATURE DATE