Patient History

Please print out and thoroughly complete (print) the following information. Bring the completed form to our office at the time of your first visit.

Date: _____/_____/_____ Name: _____

DOB: _____/_____/_____ Are you diabetic? ☐Yes ☐ No If yes, are you on Insulin ☐ Yes ☐ No

Please describe the problem that brought you to our office today and its cause if you know it: _____

_____

My main problem is: on the left foot ☐ on the right foot ☐ on both feet ☐ Other_____

How long have you had this problem/pain? _____ days _____ weeks _____ months _____ years

In a scale from 1 to 10 (10 being the worse) How painful is it: _____

My pain is : ☐ Shooting pain ☐ Burning pain ☐ Itching Other (describe)_____

☐ Throbbing pain ☐ Aching pain ☐ Tingling _____

☐ Sharp Pain ☐ Stabbing pain ☐ Numbness _____

When is your pain/problem worse: _____

_____

Describe any self treatment you have performed:_____

Have you been treated by anyone for this problem? ☐Yes ☐No, by whom?:_____

What was done?_____

Is this an injury? ☐Yes ☐ No, if yes, date of Injury: ____/____/____ Is this an injury work related? ☐Yes ☐ No

Do you have or have you ever been treated for:

☐ Stroke	☐ Heart Condition	☐ High Blood Pressure
☐ Phlebitis	☐ Vascular Disease	☐ Bleeding problems
☐ Diabetes	☐ Poor Circulation	☐ Headaches
☐ Hepatitis	☐ Liver Disease	☐ Anemia
☐ Gout	☐ Arthritis	☐ Osteoporosis
☐ Sciatica	☐ Rheumatic Fever	☐ Lyme's Disease
☐ Alzheimer's	☐ Thick Scar	☐ Hearing Disorder
☐ Epilepsy	☐ Nerve Disorder	☐ Psychiatric Disorder
☐ Glaucoma	☐ Kidney Disease	☐ Thyroid Problem
☐ Asthma	☐ Lung Disease	☐ Tuberculosis
☐ Cancer	☐ Stomach Ulcer	☐ HIV ☐ AIDS

Other (s): _____

Do you have any type of vascular grafts, artificial joints, heart Valve implant or other:_____

Please List all Surgeries you have had:_____

_____

_____

_____

_____

_____

Allergies: Is there a history of skin reaction or other outward Reaction Or sickness following an injection, oral or topical Administration

	Yes	No		Yes	No
Penicillin	☐	☐	Codeine	☐	☐
NSAID's	☐	☐	Sulfa drugs	☐	☐
Morphine	☐	☐	Adhesive tape	☐	☐
Demerol	☐	☐	Shrimp, Iodine	☐	☐

Other _____

List family members who have had:

Diabetes _____

Arthritis _____

Stroke _____

Cancer _____

Foot problems _____

Heart Problems _____

High Blood Pressure _____

Birth Defects _____

Do you smoke now ☐Yes ☐No ___Packs/day x____ years

Did you ever smoke ☐Yes ☐No ___packs/day x____ years

If you quit, When did you do so?_____

Alcoholic beverages? What type and how much?: _____

_____

# of Children _____ Are you currently pregnant? _____

Please, list below any **Medications** you are taking

_____

_____

_____

_____

_____

_____

_____

Please provide any additional information you think is relevant or important: _____

_____

_____

_____

_____

Height:_____ Weight: _____ Shoe Size:_____

SIGNATURE _____ DATE _____/_____/_____