PODIATRIC HISTORY

Name:_____ Birth date:_____

What is the chief complaint for which you came to be treated?

_____

Have you ever been to a Podiatrist before?_____ If yes list name and last visit.

_____

Cigarette/Tobacco Use_____ Years smoked_____

Your occupation_____

Athletic activities in which you participate. (please list and indicate frequency)

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	**Yes**	**No**
Athlete's Foot	**Yes**	**No**
Bunions	**Yes**	**No**
Corns and Calluses	**Yes**	**No**
Cramps or Numbness in Feet or Legs	**Yes**	**No**
Flat Feet	**Yes**	**No**
Foot or Leg Cramps	**Yes**	**No**
Heel Pain	**Yes**	**No**
Ingrown Toenails	**Yes**	**No**
Plantar Warts	**Yes**	**No**
Swelling in Ankles or Feet	**Yes**	**No**
Tired Feet	**Yes**	**No**

ALLERGIES:

ADHESIVE/TAPE	**YES**	**NO**	**LOCAL ANESTHETICS**	**YES**	**NO**
ANTICOAGULANT THERAPY	**YES**	**NO**	**NOVOCAINE**	**YES**	**NO**
ASPIRIN	**YES**	**NO**	**PENICILLIN**	**YES**	**NO**
CODEINE	**YES**	**NO**	**SEAFOODS**	**YES**	**NO**
DEMEROL	**YES**	**NO**	**SULFA**	**YES**	**NO**
IODINE	**YES**	**NO**			

PLEASE LIST ANY OTHER ALLERGIES IF NOT LISTED ABOVE:_____

_____

Surgeries you have had_____

Hospitalization other than for surgeries listed_____

FAMILY PHYSICIAN:_____LAST VISIT DATE:_____

Are you now, or have you been, under any other doctor's care for ANY reason over the past two years?
YES NO If YES, Please explain:_____

_____