NEW PATIENT HISTORY FORM

NAME **DATE**

CHIEF COMPLAINT

Please indicate the reason for your visit today:(include all complaints)

Have You Seen A Podiatrist Before? YES NO Date of Last visit:_____

When did your problem begin?

What makes your problem worse?

What makes your problem better?

Which part of your foot hurts?

On a scale of 1 to 10, how would you rate your pain?

How would you describe your pain?

PAST MEDICAL HISTORY (list diagnosed medical problems including foot/ankle issues)

If you have diabetes, who is your diabetic physician?

What Type of Diabetes Do You Have? _____ **How long have you had diabetes?**

PAST SURGERIES (List any surgeries in the past 5 years and complications, if any)

Have you ever had a blood transfusion? YES NO

MEDICATIONS: ***(if you have a list we can copy it for you)- Please list over the counter drugs also***

DRUG NAME	Dosage	Frequency Taken

ALLERGIES

Please list all allergies - Include the type of reaction you have to the allergy

Name	Reaction You Had
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Please indicate any family history in the following areas - also indicate the family member

Condition	Mark if Yes	Family Members
DIABETES		
CANCER		
HEART CONDITIONS		
HIGH BLOOD PRESSURE		

SOCIAL HISTORY

Do You Smoke? YES NO Currently _____ Former_____ How Much?

Are you interested in quitting smoking? YES NO

Do You Use Alcohol? YES NO

Do You Use Recreational Drugs? YES NO

PLEASE PROVIDE US WITH YOUR CURRENT

HEIGHT _____ ***WEIGHT*** _____ **SHOE SIZE**_____

Review of Systems (Please circle any symptoms you are CURRENTLY experiencing)

Constitutional	Cardiovascular	Musculoskeletal	Hematologic	Neurological
Weight Loss	Chest Pain/Pressure	Joint Stiffness	Anemia	Headache
Fever or Chills	Swelling Feet/ Ankles	Joint Swelling	Bruising	Dizziness
Weakness	Palpitations	Pain in Walking	Bleeding	Numbness
Fatigue	Edema	Muscle Pain		Tingling
Anxiety	Cold Feet			Paralysis

TREATMENT CONSENT

I hereby give consent and permission for the doctor to treat me for the above conditions. He will inform me and include me in any decisions regarding the treatment of my feet, ankles and lower legs. To the best of my knowledge the above information is true and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, or Guardian

_____ Date_____