All Podiatry Group
Complete Medical & Surgical Footcare

PATIENT NAME:_____

PLEASE LIST THE PROBLEM THAT BRINGS YOU IN TODAY: _____

_____

_____

ONSET: Gradual___ Sudden___ DURATION: ___Days ___Weeks ___Months ___Years

INJURY: _____ TYPE OF PAIN: _____

PREVIOUS TREATMENT: _____

PAIN: On___ Off___ WEIGHTBEARING FOOTGEAR: _____

PLEASE MARK ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT YOU HAVE EVER HAD:

- ❑ Diabetes _____
- ❑ Cardiac _____
- ❑ Hypertension _____
- ❑ Arthritis _____
- ❑ Epilepsy _____
- ❑ Gout _____
- ❑ Nervous Disorders _____
- ❑ Ulcers _____
- ❑ Cancer _____
- ❑ TB _____
- ❑ Stroke _____
- ❑ Asthma _____
- ❑ Kidney _____
- ❑ Liver _____
- ❑ Rheumatic Fever _____
- ❑ Phlebitis _____
- ❑ Bleeding Disorders _____
- ❑ HIV/AIDS _____

❑ Other _____

_____

LIST ANY MEDICATIONS YOU ARE TAKING ON A REGULAR BASIS OR NOW: _____

_____

_____

MARK ANY OF THE FOLLOWING SURGERIES YOU HAVE HAD:

- ❑ Tonsils _____
- ❑ Appendix _____
- ❑ Hernia _____
- ❑ Gallbladder _____
- ❑ Foot _____
- ❑ Female _____
- ❑ Gastric _____
- ❑ Rectal _____
- ❑ Injuries & Fractures _____

❑ Other _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

- ❑ Penicillin _____
- ❑ Local Anesthetics _____
- ❑ Aspirin _____
- ❑ Iodine _____
- ❑ Codeine _____
- ❑ Tape _____

❑ Other _____

ALLERGIC TO ANY FOOD OR ENVIRONMENTAL SOURCES: _____

LIST ANY BLOOD RELATIVES WITH THE FOLLOWING CONDITIONS:

- ❑ Diabetes _____
- ❑ Gout _____
- ❑ Foot _____

❑ Other _____

DO YOU USE TOBACCO PRODUCTS: _____