Confidential Record from the Office

PATIENT DATA/ Emergency Numbers

First Name:	MI:	Last Name:	Your type of Job Activity/ Occupation:

Soc. Sec. No.:	Sex:	AGE:	Birthdate:	Shoe Size:	Weight:	Height:

Date:

Acct#:

Reviewed: 1. 2.

☐ NEW ☐ UPDATE

In case of emergency, please first call:
Name: ____________________
Day phone #: ____________________
Evening phone #: ____________________

Friend or Relative not living with you:
Name: ____________________
Day phone #: ____________________
Evening phone #: ____________________

Please provide your preferred Pharmacy:
Name: ____________________
Street/ City: ____________________
Phone #: ____________________

PATIENT MEDICAL HISTORY

Have you had/ been treated for:

- ☐ Lower back pain
- ☐ Childhood foot problems
- ☐ Broken foot bone(s)
- ☐ Hammertoes
- ☐ Numbness
- ☐ Leg or Foot Ulcers
- ☐ Ankle injury
- ☐ Knee pain
- ☐ High arch feet
- ☐ Bunions
- ☐ Ingrown toenails
- ☐ Neuroma
- ☐ Rash
- ☐ Arch pain
- ☐ Heel Pain
- ☐ Flat feet
- ☐ Corns/Callouses
- ☐ Warts
- ☐ Athlete's foot
- ☐ None of these

What percentage of your hours awake are you on your feet? (*Check one*)

☐ 20% ☐ 40% ☐ 60% ☐ 80% ☐ 100%

List the sport/type of dance you are active in: ____________________

Do your feet hurt at night? ☐ Yes ☐ No

Do you have difficulty walking? ☐ Yes ☐ No

Do you get leg cramps? ☐ Yes ☐ No

Any pain in calves or buttocks when walking? ☐ Yes ☐ No

Is the pain relieved by rest? ☐ Yes ☐ No

Do you have or have you ever been treated for:

- ☐ Stroke
- ☐ Phlebitis
- ☐ Anemia
- ☐ Hepatitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Broken Bone
- ☐ Scarlet Fever
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Poor Circulation
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Gout
- ☐ Nerve Disorder
- ☐ Osteoporosis
- ☐ Rheumatic Fever
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ A Heart Condition
- ☐ Vascular Disease
- ☐ Kidney Disease
- ☐ Tuberculosis
- ☐ Lyme's Disease
- ☐ Psychiatric Disorder
- ☐ Keloid/Thick Scarring
- ☐ Stomach Ulcer
- ☐ None of these

Do you have vascular grafts? *(If yes, explain below)* ☐ Yes ☐ No

Do you have joint implants? *(If yes, explain below)* ☐ Yes ☐ No

Do you have replacement heart valves? ☐ Yes ☐ No

Are you now under active chemotherapy? ☐ Yes ☐ No

Have you had any other serious illness? *(List below)* ☐ Yes ☐ No

Have you ever been hospitalized or been under medical care over 24 hours? ☐ Yes ☐ No

Have you had any surgery? ☐ Yes ☐ No

Had Surgery for::	Date of Surgery:	w/ complications of:

Anything else that you want to tell the doctor? ☐ Yes ☐ No

Illnesses/ Explanations: ____________________

List the relationship to you of family members who have had:

Diabetes	________	Foot Problems	________
Arthritis	________	Heart Attack	________
Stroke	________	High Blood Pressure	________
Cancer	________	Birth Defects	________

# of childbirths:_____ Are you currently pregnant? ☐ Yes ☐ No

Are you slow to heal after cuts? ☐ Yes ☐ No

Any abdominal bruising, pleading or scarring? ☐ Yes ☐ No

Are you taking Insulin? ☐ Yes ☐ No

Are you currently taking any other medications? ☐ Yes ☐ No

Medication	For What Problem?	For How Long?

Do you smoke now? ☐ Yes ☐ No Packs/day _____ Years _____

Did you ever smoke? ☐ Yes ☐ No Packs/day _____ Years _____

If you quit, when did you do so? ____________________

Alcoholic beverages? *(Check one)*

☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Recreational drugs? *(Check one)*

☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Allergies: Is there a history of skin reaction or other outward reaction or sickness following injection, oral or topical administration of:

(Check box that applies)	*No*	*Yes*	*If yes, what happens?*
Penicillin	☐	☐	
Other antibiotics (list below)	☐	☐	
Morphine	☐	☐	
Codeine	☐	☐	
Demerol	☐	☐	
Other narcotics (list below)	☐	☐	
Novocaine	☐	☐	
Other anesthetics (list below)	☐	☐	
Aspirin	☐	☐	
Empirin, Tylenol (if yes, circle)	☐	☐	
Advil, Aleve, or Motrin (circle)	☐	☐	
Other pain remedies (list below)	☐	☐	
Sulfa drugs	☐	☐	
Adhesive tape	☐	☐	
Shrimp, Iodine or Merthiolate	☐	☐	
Any other drugs or medications	☐	☐	

Allergic to/ Reaction: ____________________