

New York Foot Group, L.L.P.
Patient Medical History

Name _____ Date _____

CHIEF CONCERN

Please describe your current foot problem: _____

How long have you had this problem? _____

Describe the onset: Sudden Gradual

Since onset the problem has Worsened Improved Not Changed

Describe any previous treatments for your current problem: _____

Past Medical History

Have you ever been DIAGNOSED with any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis Osteo | <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Arthritis Rheumatoid | <input type="checkbox"/> Gastro-Esophageal | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | Reflux Disease (GERD) | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Arrhythmia | <input type="checkbox"/> Nervous Disorders | |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sickle Cell | |

List *all* past surgeries (not limited to feet) _____

MEDICATIONS AND ALLERGIES

Medications (Please list all current prescription and over the counter medications): NONE

Allergies: Adhesive Tape Aspirin Codeine Iodine Latex Local Anesthetic
 Malignant Hyperthermia Metal Penicillin Sulfa Other _____

Reactions: _____

Do you smoke? No Yes _____
Packs per Day

Do you drink alcohol? No Yes

Frequency: Occasionally/Frequently/Rarely
(Circle One)

Does your family have a history of foot problems? No Yes _____
Please list all problems

Have you ever experience any of the following problems with your feet:

Burning Coldness Cramping Dryness Excessive Sweating Weakness
 Numbness Pain Redness Swelling Ulcers Itchiness
 Other _____ NONE