

MEDICAL INFORMATION

This Information is Important For Our Records and Your Health

Patient Name: _____ DOB: _____

Describe your foot problem.

Have you tried anything to treat the problem?

How long has it been bothering you?

Days _____ Weeks _____ Months _____ Years _____

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

- | | | |
|---|--|---|
| <input type="checkbox"/> ANKLE PAIN | <input type="checkbox"/> ATHLET'S FOOT | <input type="checkbox"/> BUNIONS |
| <input type="checkbox"/> CORNS AND CALLUSER | <input type="checkbox"/> NUMBNESS IN FEET/LEGS | <input type="checkbox"/> FLAT FEET |
| <input type="checkbox"/> FOOT/LEG CRAMPS | <input type="checkbox"/> HEEL PAIN | <input type="checkbox"/> INGROWN TOENAILS |
| <input type="checkbox"/> PLANTAR WARTS | <input type="checkbox"/> SWELLING IN ANKLES/FEET | <input type="checkbox"/> TIRED FEET |

Current Height: _____ Current Weight: _____ Shoe Size: _____

3. ALLERGIES. Are you allergic or sensitive to any of the following? Please check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> ACETAMINOPHEN | <input type="checkbox"/> ADHESIVE TAPE | <input type="checkbox"/> ASPRIN |
| <input type="checkbox"/> CODEINE | <input type="checkbox"/> ERYTHROMYCIN | <input type="checkbox"/> IODINE |
| <input type="checkbox"/> KEFLEX | <input type="checkbox"/> LATEX | <input type="checkbox"/> METAL ON SKIN |
| <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> SOAP | <input type="checkbox"/> SULFA DRUGS |
| <input type="checkbox"/> X-RAY DYE | <input type="checkbox"/> OTHER _____ | |

4. FAMILY HISTORY.

Is there a family (blood relative) history of any of the following medical problems?

- | | | |
|---|---|--|
| <input type="checkbox"/> ALLERGIES TO MEDICATIONS | <input type="checkbox"/> ANGINA | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> ATHEROSCLEROSIS | <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> BUNIONS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> CIRCULATION OF THE LEGS/FEET | |
| <input type="checkbox"/> DEMENTIA | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> FLAT FEET | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> HAMMERTOE(S) |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> HEART FAILURE |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> MELANOMA | <input type="checkbox"/> NEUROLOGICAL |
| <input type="checkbox"/> OSTEOARTHRITIS | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> RHEUMATOID ARTHRITIS | <input type="checkbox"/> STROKE | <input type="checkbox"/> VARICOSE VEINS |
| <input type="checkbox"/> OTHER _____ | | |

MOTHER Living Deceased Cause of Death _____

FATHER Living Deceased Cause of Death _____

BROTHER(S) Living Deceased Cause of Death _____

SISTER(S) Living Deceased Cause of Death _____

5. MEDICATIONS.

Gretchen L. Heutsche, DPM & Angela M. Ostroski, DPM

Specializing in Podiatric Medicine • office: (734) 994-3668

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What medications do you currently take regularly? Please include prescriptions, over-the-counter medicines, and vitamins. (Bring list.)

Name of pharmacy or drug store that you use. _____

Phone number _____

6. MEDICAL HISTORY.

Please check which best describes your general health: Excellent Good Fair Poor

- | | | |
|--|---|--|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Foot/Leg cramp |
| <input type="checkbox"/> Frequent Infection | <input type="checkbox"/> Gout | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hemophillia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Slow or non-healing wounds | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Swelling of the feet/ankles | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Unexplained fever/weight loss | <input type="checkbox"/> Varicose Veins | |
| <input type="checkbox"/> Other _____ | | |

7. REVIEW OF SYSTEMS. Please check if you have regularly.

General:

- Weight changes Weakness Fatigue Fever

HEENT:

- Headaches Dizziness Glaucoma Eye problems
Ringing Imbalance Hearing loss Sinus
Deviated septum False teeth Sores

Cardiovascular:

- Angina Blood clot Chest pain Heart attack
Heart disease Heart palpitations High blood pressure Leg cramps when walking
Swelling feet/ankles Varicose veins

Dermatological:

- Corns/callus Deformed/thickened toenails Eczema Itching
Moles Psoriasis Rash Skin cancer
Ulcers

GI:

- Acid Reflux IBS Ulcers

Hematologic:

- Anemia Aspirin Bleeding disorder Coumadin

Musculoskeletal:

- Arthritis-RA/OA Back pain Fractures Joint pain Muscle pain
Sprains Stiffness

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Neurological:

- Loss of balance Loss of feeling Loss of function Numbness
 Paralysis Sciatica Spine injury/disease Stroke
 Tingling

Psychological:

- Alzheimer's Anxiety Depression Mental illness

Respiratory:

- Asthma Emphysema Lung Cancer Shortness of breath

Do you have any artificial joints?

Hip Yes No Right / Left

Knee Yes No Right / Left

Do you have a Heart Valve Implant or Murmur? Yes No

Women Only:

Are you pregnant? Yes No

Are you Breastfeeding? Yes No

Taking Oral Contraceptives? Yes No

Do you have **diabetes**? Yes No If yes, do you take insulin? Yes No

Number of years that you've had diabetes _____

Date of last Tetanus (TDaP, TD) immunization?

Please list all surgeries you have had.

Hospitalizations other than for the surgeries listed.

Are you under a physician's care? Yes No

If yes, for what condition?

Physician _____

Physician's Phone Number _____

Date you last saw this Doctor _____

May we contact your physician about your health? Yes No

Do you smoke? Yes No

Number of packs per day _____ How many years have you smoked? _____

Did you previously smoke? Yes No Number of years _____

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Do you drink alcohol or beer? Yes No

If yes, how much? Less than 1-2 per week 1-2 per day More than 2 per day

Do you drink caffeinated beverages? Yes No Number of cups/cans per day_____

Employment: Sit at job Stand at job Stand & walk at job Retired Homemaker

Do you participate in any athletic activities? (Please list and indicate frequency.)

8. CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to examine, administer and after consultation, perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my feet.

Signature

Date