

Barrett Parkway Foot and Leg Specialists PC

Patient Medical History

Patient Name	First	Middle	Last	Birthdate	Age	Gender	Height	Weight	Shoe Size
In case of emergency notify: Phone number:									
Occupation:									
Friend or relative not living with you: Phone number:									
Primary care Physician: Phone number: Date last seen:									
Have you had/ been treated for:									
Foot Problems (check)					Medical Problems (check)				
Corns/Calluses	Leg/ foot ulcer	Walking problems	High blood pressure	Heart condition					
Hammertoes	Cramps leg/foot	Low back pain	Lung disease	Bleeding disorder					
Fungal nails	Knee pain	Warts	Diabetes	Thyroid disorder					
Neuroma	Bunion	Arch pain	Heart attack	Vascular disease					
Athletes foot	Ingrown nails	Foot Numbness	Arthritis	Keloid scar					
Sprain Ankle	Flat feet	High arch feet	Nerve disorder	Psychiatric disorder					
Heel pain	Fracture foot/ ankle	In-toeing	Kidney disease	Stomach ulcer					
Rash on feet	Foot infections	None	Liver disease	Anemia					
Have you ever worn orthotics? Yes No					Stroke Gout				
Does foot pain limit your activities? Yes No					Phlebitis Asthma				
Do you have difficulty walking? Yes No					Cancer AIDs				
List physical activities you do:					Osteoporosis None				
Surgical History (List type of surgery and approximate date)					1. 2.				
3. 4.					5. 6.				
Medications: (name only- include herbals and vitamins)					Allergies: (check)				
1.		2.		Penicillin		Aspirin			
3.		4.		Other Antibiotics		Sulfa			
5.		6.		Codeine		Novocain			
7.		8.		Tape		Iodine			
9.		10.		Ibuprofen/Advil		Pain Medications			
11.		12.		Other:					
Family History (check if someone in your family has had)					Personal History (check if yes)				
Diabetes		High blood pressure		Are you slow to heal		Do you bleed / bruise easily			
Stroke		Cancer		Do you smoke		Do you drink alcohol			
Heart Attack		Arthritis		Do you take illegal drugs		Do you take insulin			
Foot Problems		Problems with anesthesia		Other medical history:					
Today's Problem									
Describe the problem and the cause if known:									
It causes me difficulty when:					How long has the problem been present?				
The nature of the problem is:					The severity of the problem is:				
Previous medical treatment by you or another doctor:									
The type of symptom is: (check)					Location of the problem:			Right	Left
Shooting pain		Throbbing pain		Ball of foot	Toes	Heel	Arch		
Sharp pain		Burning pain		Ankle/Calf	Inside	Outside	Top		
Itching		Aching pain		Bottom	Front/Back	Deep	Inside Joint		
Tenderness	Dull pain	Tingling	Numbness	Other:					

Referred by: Physician Patient Insurance Company Yellow Pages Other:
 Today's Date: _____