

Medications: _____

Allergies: ___ Penicillin ___ Sulfa ___ Latex ___ Metal ___ Shellfish ___ Iodine ___ Adhesive tape
___ Codeine ___ Anesthetic Other: _____

Social History: How frequently do you drink beer, wine, and/or liquor? _____ How much? _____
Do you smoke? _____ How many packs/cigars a day? _____ How many years? _____
Do you take any illicit drugs? _____

Family History: List any family health problems? (Diabetes, Heart disease, Cancer, Foot problems?)

Primary Care Physician: _____ **Date Last Seen:** _____

Review of Systems: Have you experienced any of these symptoms over the last few days?

General-

- Weight loss or gain
- Fatigue
- Fever or chills
- Weakness
- Trouble sleeping

Endocrine-

- Heat or cold intolerance
- Sweating
- Excessive Thirst

Psychiatric-

- Nervousness
- Depression
- Memory loss
- Stress

Head-

- Headache
- Head injury

Ears-

- Decreased hearing
- Ringing in ears
- Ear ache

Skin-

- Rash
- Lump
- Itching
- Dryness
- Color changes
- Hair and nail changes

Respiratory-

- Cough
- Sputum
- Shortness of breath
- Wheezing
- Difficulty breathing

Neck-

- Lumps
- Swollen glands
- Pain
- Stiffness

Nose-

- Stuffiness
- Discharge
- Itching
- Nosebleeds

Gastrointestinal-

- Heartburn
- Change in appetite
- Nausea
- Constipation
- Diarrhea

Hematologic-

- Ease of bruising
- Ease of bleeding

Cardiovascular-

- Chest pain or discomfort
- Tightness
- Palpitations

Vascular-

- Calf pain with walking
- Leg Cramping
- Swelling in the legs

Musculoskeletal-

- Muscle or joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints

Eyes-

- Glasses/Contacts
- Blurred vision

Throat-

- Bleeding
- Dentures
- Sore tongue
- Dry mouth
- Sore throat
- Hoarseness

Neurologic-

- Dizziness
- Fainting
- Seizures
- Numbness
- Tingling
- Tremor

Urinary-

- Frequency
- Urgency
- Blood in urine
- Incontinence

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

SIGNATURE: _____ DATE: _____