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PODIATRIC HISTORY

Patient Name: ______________________________________ *Date of Birth:* _____________________

Please list the chief complaint for which you came to be treated (include foot, ankle, knee, thigh and hip complaints)

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Have you ever seen a podiatrist before? Yes ____________ No ___________

If yes, please list: Dr. Name: ________________________Date of last visit: ________________________

Is there any personal or family history of diabetes? ____

Your occupation(s): ____

Cigarette/ Tobacco use: __________________________ Years Smoked: ___________________________

Athletic activities in which you participate: (please indicate frequency)

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Please indicate which foot problems you have had in the past:
Ankle Pain: Yes ________ No________ Athletes Foot: Yes ________ No________
Bunions: Yes ________ No________ Corns & Calluses: Yes ________ No________
Cramps/ Numbness in feet or legs Yes ________ No________
Flat feet: Yes ________ No x_______ Foot or Leg Cramps: Yes ________ No________
Heel Pain: Yes ________ No________ Ingrown toenails: Yes ________ No________
Plantar Warts Yes ________ No________ Tired Feet: Yes ________ No________
Swelling in ankles or feet: Yes ________ No________
Other concerns:

____

TREATMENT CONSENT

I hereby consent and give permission to the doctor and their designated assistants to administer and perform such procedures upon as the Doctor deems necessary and that have been fully discussed with me beforehand.

____

Signature of patient, parent, guardian or personal representative *Date*

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Print Name of patient, parent, guardian or personal representative *Date*