



**ANKLE AND FOOT INSTITUTE**

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**PATIENT HISTORY & PHYSICAL**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_ FAMILY DR. PHONE#: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ AGE: \_\_\_\_\_ SHOE SIZE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

HOW LONG HAS PROBLEM BEEN THERE? \_\_\_\_\_

HAVE YOU RECEIVED ANY TREATMENT FOR THIS CONDITION? IF YES, PLEASE LIST NAME OF TREATING PHYSICIAN AND WHEN YOU WERE TREATED? \_\_\_\_\_

DO YOU HAVE ANY OTHER FOOT PROBLEMS? \_\_\_\_\_

**MEDICAL HISTORY (CIRCLE IF POSITIVE):**

- |                  |                          |                      |
|------------------|--------------------------|----------------------|
| HYPERTENSION     | DIABETES (IDDM OR NIDDM) | NEUROLOGIC           |
| HEPATITIS        | RENAL                    | ASTHMA               |
| LEG CRAMPS       | THYROID                  | SKIN                 |
| BLOOD DISORDERS  | GI                       | VISION               |
| WEIGHT CHANGE    | CANCER                   | CATARACTS            |
| TRAUMA           | CARDIAC                  | GLAUCOMA             |
| PSYCHOLOGICAL    | LIVER DISEASE            | RETINOPATHY          |
| ARTHRITIS        | STROKE/TIA               | KELOID               |
| GOUT             | CHOLESTEROL              | ANEMIA               |
| DVT/PE           | HIV/AIDS                 | TUBERCULOSIS         |
| VASCULAR DISEASE | BACK PAIN                | RHEUMATOID ARTHRITIS |

**FAMILY MEDICAL HISTORY (PLEASE LIST HEART CONDITIONS, DIABETES, ETC.):**

MOTHER: \_\_\_\_\_ FATHER: \_\_\_\_\_

SIBLINGS: \_\_\_\_\_ GRANDPARENTS: \_\_\_\_\_

**SOCIAL HISTORY (PLEASE PROVIDE QUANTITY AND FREQUENCY):**

TOBACCO: \_\_\_\_\_ ALCOHOL: \_\_\_\_\_ ILLICIT DRUGS: \_\_\_\_\_

**SURGICAL HISTORY (CIRCLE IF POSITIVE):**

- |               |                           |                     |
|---------------|---------------------------|---------------------|
| HYSTERECTOMY  | APPENDECTOMY              | GALLBLADDER SURGERY |
| TONSILLECTOMY | FOOT SURGERY OTHER: _____ |                     |

**HOSPITALIZATIONS (PLEASE LIST):**

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**OBSTETRIC (WOMEN ONLY):**

GRAVIDA (PREGNANCIES): \_\_\_\_\_ PARA (BIRTHS): \_\_\_\_\_

ARE YOU CURRENTLY PREGNANT? \_\_\_\_\_

**ALLERGIES/BAD REACTIONS TO MEDICATIONS (PLEASE LIST):**

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**MEDICATIONS (PLEASE LIST):**

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DO YOU TAKE COUMADIN OR ANY OTHER BLOOD THINNERS? YES/NO

DO YOU TAKE ANY HERBAL MEDICATIONS OR DIET MEDICATIONS? YES/NO

**EXAMINATION (PLEASE DO NOT WRITE BELOW THIS LINE):**

<b>VASCULAR:</b>	<u>RIGHT</u>	<u>LEFT</u>
PT PULSE	P/NP	P/NP
DP PULSE	P/NP	P/NP
CFT		
EDEMA		
VARICOSITIES		
DERMATOLOGIC:		
SKIN		
NAILS		
DIGITAL HAIR GROWTH		

**NEUROLOGIC:**

ANKLE CLONUS  
BABINSKI'S SIGN  
DTR'S: PATELLAR  
ACHILLES  
VIBRATORY  
SHARP PAIN

**MUSCULOSKELETAL:**

**RADIOLOGIC:**

**IMPRESSIONS:**