Record ID # 622754

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Confidential Office Medical Record

☐ Only Changes To The Previous History Information Are Noted

1 PATIENT IDENTIFICATION AND CONTACT INFORMATION

Patient Acct # Staff Entry

First Name: MI: Last Name:

Your type of Job Activity / Occupation:

☐ I prefer to be addressed as: Mr. Mrs. Miss Ms. Dr.

Soc. Sec. No.: Sex M / F Age Birth Date: / /

Shoe Size: Weight: Height:

☐ I prefer to be addressed by: ○ First Name ○ Nick Name:

Phone Numbers For Contacting You:

Day: (_____) _____-_____

Evening: (_____) _____-_____

Cell/Pager: (_____) _____-_____

In Case of Emergency, Please Call:

Day: (_____) _____-_____

Evening: (_____) _____-_____

Please Provide Your Preferred Pharmacy:

Street / City: _____

Day: (_____) _____-_____

2 COMPREHENSIVE PATIENT MEDICAL HISTORY

ROS/PFSH

Have you had/been treated for:

☐ Warts ☐ Athlete's Foot
☐ Corns/Calluses ☐ Fungal Nails ☐ Ingrown nails
☐ Leg or Foot Ulcers ☐ Neuroma ☐ Foot Numbness
☐ Broken foot bone(s) ☐ Broken Ankle ☐ Ankle sprain
☐ Hammer/Mallet toes ☐ Bunions ☐ Flat feet
☐ Cramps in legs/feet ☐ Arch pain ☐ High arch feet
☐ Lower back pain ☐ Knee pain ☐ Heel pain
☐ Gait (Walking) problems ☐ In-toeing ☐ Toe walking
☐ Childhood foot problems ☐ Rash ☐ *NONE of these*

Did you previously or do you now wear:

Shoe inserts? Y N Still using them? Y N Do or did they help? Y N

Orthotics? Y N Still using them? Y N Do or did they help? Y N

The orthotics were obtained from: ○ Another Podiatrist ○ An Orthopedist ○ A Physical Therapist ○ A Chiropractor ○ Other: _____

Are your first steps out of bed painful? Y N ... then subsides? Y N

Do you get leg cramps ...during the Day? Y N ...at Night? Y N

Percent of waking hours spent on your feet? 20% 40% 60% 80% 100%

List the sports/type of dance your are active in:

_____

Does foot pain limit your desired activities? ☐ Yes ☐ No

Do you have any difficulty in walking? ☐ Yes ☐ No

Any pain in calves or buttocks when walking? ☐ Yes ☐ No

Is the pain relieved by stopping & standing still? ☐ Yes ☐ No

Do you have or have you ever been treated for:

☐ Stroke ☐ Heart Attack ☐ High Blood Pressure
☐ Phlebitis ☐ Vascular Disease ☐ A Heart Condition
☐ Anemia ☐ Poor Circulation ☐ Eyes:Glaucoma/Manicular Deg.
☐ Diabetes ☐ Kidney Disease ☐ Keloid/Thick Scar
☐ Gout ☐ Osteoporosis ☐ Alzheimer's
☐ Sciatica ☐ Lyme's Disease ☐ Rheumatic Fever
☐ Arthritis ☐ Headaches ☐ Hearing/Ear Disorder
☐ Epilepsy ☐ Nerve Disorder ☐ Psychiatric Disorder
☐ Asthma ☐ Lung Disease ☐ Tuberculosis
☐ Hepatitis ☐ Liver Disease ☐ Thyroid Problem
☐ Dark Urine ☐ Chronic Lt. Stool ☐ Unexplained Weight Loss
☐ Cancer ☐ Stomach Ulcer ☐ *NONE of these*

☐ Other(s): _____

Do you have vascular grafts? *(If yes, explain below)* ☐ Yes ☐ No

Do you have joint implants? *(If yes, explain below)* ☐ Yes ☐ No

Do you have replacement heart valves? ☐ Yes ☐ No

Are you now under active chemotherapy? ☐ Yes ☐ No

Have you had any other serious illness? *(List below)* ☐ Yes ☐ No

Have you had any surgery? *(If yes, explain below)* ☐ Yes ☐ No

Have you ever been hospitalized or been under medical care over 24 hrs? *(If yes, explain below)* ☐ Yes ☐ No

I Had Surgery for: on date of: w/ complications of:

_____ _____ _____

_____ _____ _____

_____ _____ _____

List relationship to you of family members who have had:

Diabetes _____ Foot Problems _____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

# of childbirths ___ Are you currently pregnant? ☐ Yes ☐ No

Are you slow to heal after cuts? ☐ Yes ☐ No

Any abnormal bruising, bleeding or scarring? ☐ Yes ☐ No

Do you smoke now? ☐ No ☐ Yes Packs/day ___ Years___

Did you ever smoke? ☐ No ☐ Yes Packs/day ___ Years___

If you quit, when did you do so? _____

Alcoholic beverages? (Circle one) ○ None ○ Rarely ○ Moderately ○ Daily ○ Quit

Recreational Drugs? (Circle one) ○ None ○ Rarely ○ Moderately ○ Daily ○ Quit

Please mark if you take vitamins or supplements that contain ○ *garlic,* ○ *Gingko biloba,* ○ *echinacea,* ○ *ginseng or* ○ *St. John's Wort*

Are you currently taking any medications? List below! ☐ Yes ☐ No

Are you taking Insulin? If yes, list below. ☐ Yes ☐ No

When noting frequency: A = As needed, x/ = times per D = day, W = week,

List: Medications	Dose?	How Often?	For Treatment of?
_____	_____	A, ___ x/ D W	_____
_____	_____	A, ___ x/ D W	_____
_____	_____	A, ___ x/ D W	_____
_____	_____	A, ___ x/ D W	_____
_____	_____	A, ___ x/ D W	_____

Are you taking your medications as prescribed? ☐ Yes ☐ No

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

(Check the answer box that applies)	No	Yes	*If yes, what happens?*
Penicillin	☐	☐	
Other antibiotics *(list below)*	☐	☐	
Empirin, Tylenol *(If yes, circle)*	☐	☐	
Aspirin, Advil, Aleve, or Motrin *(circle)*	☐	☐	
Celebrex, Bextra, Vioxx *(circle)*	☐	☐	
Other pain remedies *(list below)*	☐	☐	
Morphine	☐	☐	
Codeine	☐	☐	
Demerol	☐	☐	
Other narcotics *(list below)*	☐	☐	
Novocaine	☐	☐	
Other anesthetics *(list below)*	☐	☐	
Sulfa drugs	☐	☐	
Adhesive tape	☐	☐	
Shrimp, Iodine, or Merthiolate	☐	☐	
Any other drugs or medications.	☐	☐	

Others: _____

Anything else that you want to tell the doctor? ☐ Yes ☐ No

Illnesses/Explanations: _____

INITIAL HISTORY ☐ UPDATE OF HISTORY TAKEN ☐ PATIENT HISTORY AS OF ___/___/___

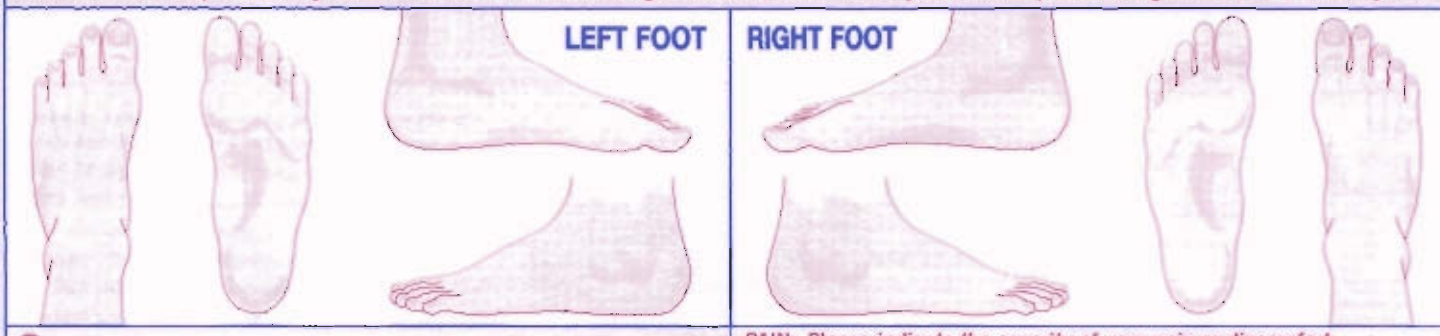
PLEASE CONTINUE ON THE OTHER SIDE TO PROVIDE ADDITIONAL DETAILS.

Patient CC# (s)

3 PATIENT'S CURRENT CHIEF COMPLAINTS — CC/HPI

Patient CC# (s)

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below the areas where you have each problem using numbers 1 & 2 to identify them.



❶ Please mark the location of your first problem or pain on the diagrams above with a number **1**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡

My first problem is ... ☐ On Left foot ☐ On Right foot ☐ On Both feet.

It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it ...

Is problem work related? Y N

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort:
0 None. . . . 1 Light . . . 2 Moderate . . . 3 Strong . . . 4 Severe

My Pain/Discomfort is:
- ☐ Shooting Pain
- ☐ Throbbing Pain
- ☐ Sharp Pain
- ☐ Burning Pain
- ☐ Itching
- ☐ Aching Pain
- ☐ Tenderness
- ☐ Dull Pain
- ☐ Tingling
- ☐ Numbness

How long ago did the problem (pain) start?:
○ days, ○ weeks, ○ months, ○ years ago

The pain from my problem occurs:
☐ while walking and/or ☐ while not walking
☐ and/or:

Previous medical treatment(s) or home remedies:

❷ Please mark the location of your second problem or pain on the diagrams above with a number **2**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡

My second problem is ... ☐ On Left foot ☐ On Right foot ☐ On Both feet.

It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it ...

Is problem work related? Y N

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort:
0 None. . . . 1 Light . . . 2 Moderate . . . 3 Strong . . . 4 Severe

My Pain/Discomfort is:
- ☐ Shooting Pain
- ☐ Throbbing Pain
- ☐ Sharp Pain
- ☐ Burning Pain
- ☐ Itching
- ☐ Aching Pain
- ☐ Tenderness
- ☐ Dull Pain
- ☐ Tingling
- ☐ Numbness

How long ago did the problem (pain) start?:
○ days, ○ weeks, ○ months, ○ years ago

The pain from my problem occurs:
☐ while walking and/or ☐ while not walking
☐ and/or:

Previous medical treatment(s) or home remedies:

4 PATIENT'S DOCTORS - PLEASE TELL US WHOM TO THANK AND WITH WHOM TO COORDINATE YOUR CARE

My:	Physician's Name:	Phone Number	City	Date Last Seen	Referred me:	I was sent or came in especially for:
Family/ Primary				/ /	Y N	2nd Opinion Surgcl Eval Consult
Specialist				/ /	Y N	2nd Opinion Surgcl Eval Consult
Other Podiatrist				/ /	Y N	2nd Opinion Surgcl Eval Consult

5 FOR DOCTOR'S USE - OBSERVATIONS & COMMENTS

☐ Patient was ○ assisted in completion of this record by or was ○ unable to complete without the help of:

☐ Translation was done by in ○ Spanish, ○

☐ Additional Information† obtained from ○ Family/Care givers and/or ○ Physician(s)

☐ Lab Reports† and/or ☐ Previous Medical Records† were reviewed. ☐ X-rays† brought by patient from were reviewed.

† Elaborations:

I have reviewed the information provided above ☐ My annotations to patient's entries are marked in: (INK COLOR)

Doctor's Signature X Date / / ☐ See Additional Documentation

☐ Only Changes To The Previous History Information Are Noted

2010 Elements of HPI (History of Present Illness): • Location • Severity • Context • Quality • Duration • Modifying Factors • Associated Signs & Symptoms

PATIENT HISTORY

Patient Name: Last, First, Middle

SSN

Sex Age DOB / /