Patient# _____ Date _____

CENTRAL FOOT AND ANKLE ASSOCIATES, PA

Linda D. Nachmani, DPM Maria J. Bertorello, DPM

Patient: _____
Last name First name Initial

Shoe Size:_____ Weight: _____ Height: _____

HISTORY OF PRESENT ILLNESS:

1. What specific problem brings you to our office today? _____

2. Where is the pain/condition located? _____Left foot/ankle? _____Right foot/ankle? _____Both?

3. How would you describe the nature of your pain?
   Sharp ____Dull ____Aching ____ Burning ____Radiating ____Itching ____Stabbing Other_____

4. How would you rate your pain on a scale from 0 to 10?
   (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)

5. What part of the foot/ankle is the pain/condition located? _____
6. How long ago did this problem first start? _____
7. Was the onset of pain sudden or gradual? _____
8. Has the problem stayed the same, worsened, or improved over time? _____
9. What seems to make the pain/condition feel worse? ____Walking ____Standing ____ Resting ____Dress Shoes
   ____High heels ____Flat shoes ____Any closed shoe ____Daily activities ____Exercise
   Other: _____
10. What type of shoe do you wear most often? ____Dress Shoes ____High heels ____Flat shoes ____Athletic _____Other
11. What makes the condition feel better? _____
12. What treatments have you had for this condition? _____
13. How has this condition affected your lifestyle or ability to work? _____
14. Is this problem the result of an injury? _____ Yes/No If yes, is it work related? ____ Yes/No
15. Have you ever been treated for a foot/ankle condition by a doctor in the past? _____
16. Do you wear custom orthotics? ____ Yes/No

ALLERGIES:

Are you allergic or sensitive to any of the following (please circle)?

Aspirin Codeine Iodine Latex Metals Morphine Neosporin Novocain Penicillin Shellfish Sulfa Tape

Other: _____

PAST MEDICAL HISTORY: (Please circle all that apply)

Acid Reflux	Y	N
Anemia	Y	N
Arthritis	Y	N
Asthma	Y	N
Back Trouble	Y	N
Bladder Infections	Y	N
Bleeding tendencies	Y	N
Blood Clots	Y	N
Blood Transfusion	Y	N
Bronchitis/Emphysema	Y	N
Cancer	Y	N
Diabetes	Y	N
Fibromyalgia	Y	N
Gout	Y	N
Heart Attack	Y	N
Heart disease/failure	Y	N
Hepatitis	Y	N
HIV+ or AIDS	Y	N

High blood pressure	Y	N
Kidney disease	Y	N
Liver disease	Y	N
Low blood pressure	Y	N
Migraine headaches	Y	N
Mitral valve prolapse	Y	N
Neuropathy	Y	N
Open Sores	Y	N
Pneumonia	Y	N
Polio	Y	N
Rheumatic fever	Y	N
Sickle cell disease	Y	N
Skin disorder	Y	N
Sleep apnea	Y	N
Stomach ulcers	Y	N
Stroke	Y	N
Thyroid disease	Y	N
Tuberculosis	Y	N

Current Medications: (Include over-the-counter and supplements)

_____

_____

_____

Past Surgical History: (List all procedures and hospitalizations you have had in the past)

_____

_____

_____

Social History:

Use of alcohol: _____Never _____Rare _____Occasional _____Moderate _____Daily

_____Previous alcohol abuse

Do you use tobacco? ____Yes ____No Type: _____ Quantity: _____ Quit Date: _____

Do you use drugs? ____Yes ____No Type/Frequency: _____ Quit Date: _____

How much of the day do you spend on your feet? _____25% _____50% _____75% _____100%

What type of exercise do you do regularly? _____

Review of Systems: Are you currently experiencing or have you ever been treated for any of the following? (Please check all that apply)

CONSTITUTIONAL

_____Nausea/Vomiting

_____Fever / Chills

_____Recent weight change

EYES

_____Eye disease or injury

_____Wear glasses/contacts

_____Blurred or double vision

EARS/NOSE/MOUTH/THROAT

_____Hearing-loss

_____Nose bleeds

_____Sore throat

_____Sinus problems

_____Difficulty Swallowing

CARDIOVASCULAR

_____Chest Pain

_____Palpitations

_____Heart disease

_____Murmur

_____Arrhythmia

_____Leg pain when walking

ENDOCRINE

_____Hormonal problem

_____Excessive thirst/urination

_____Heat or cold intolerance

_____Dry Skin

_____Wear glasses/contacts

_____Change in hat or glove size

GASTROINTESTINAL

_____GI upset

_____GI or rectal bleeding

_____Abdominal pain

GENITOURINARY

_____Frequent urination

_____Burning or painful urination

_____Kidney stones

_____Female: # of pregnancies

_____Female: # of miscarriages

MUSCULOSKELTAL

_____Joint pain

_____Stiffness or swelling

_____Low back pain

RESPIRATORY

_____Difficulty breathing

_____Shortness of breath

_____Lung disease

INTEGUMENTARY

_____Edema or swelling

_____Rash

_____ Itching

NEUROLOGICAL

_____ Headaches

_____Seizures

_____Numbness

_____Tingling

_____ Burning

PSYCHIATRIC

_____Anxiety

_____Depression

_____Nervousness

HEMATOLOGICAL

_____ Phlebitis

Family History: (Please list all medical conditions that run in your family)

_____

_____

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____ _____

Print Name of Patient, Parent or Guardian Signature of Patient, Parent or Guardian Date

_____ _____

Signature of Doctor Date