PREFERRED NAME: ______________________________

LOCAL PHARMACY (please be specific with location): ____

HEIGHT: ___________ WEIGHT: ____________ SHOE SIZE: ___________ (NARROW/REGULAR/WIDE/XTRA WIDE)

WHAT SPECIFIC FOOT PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

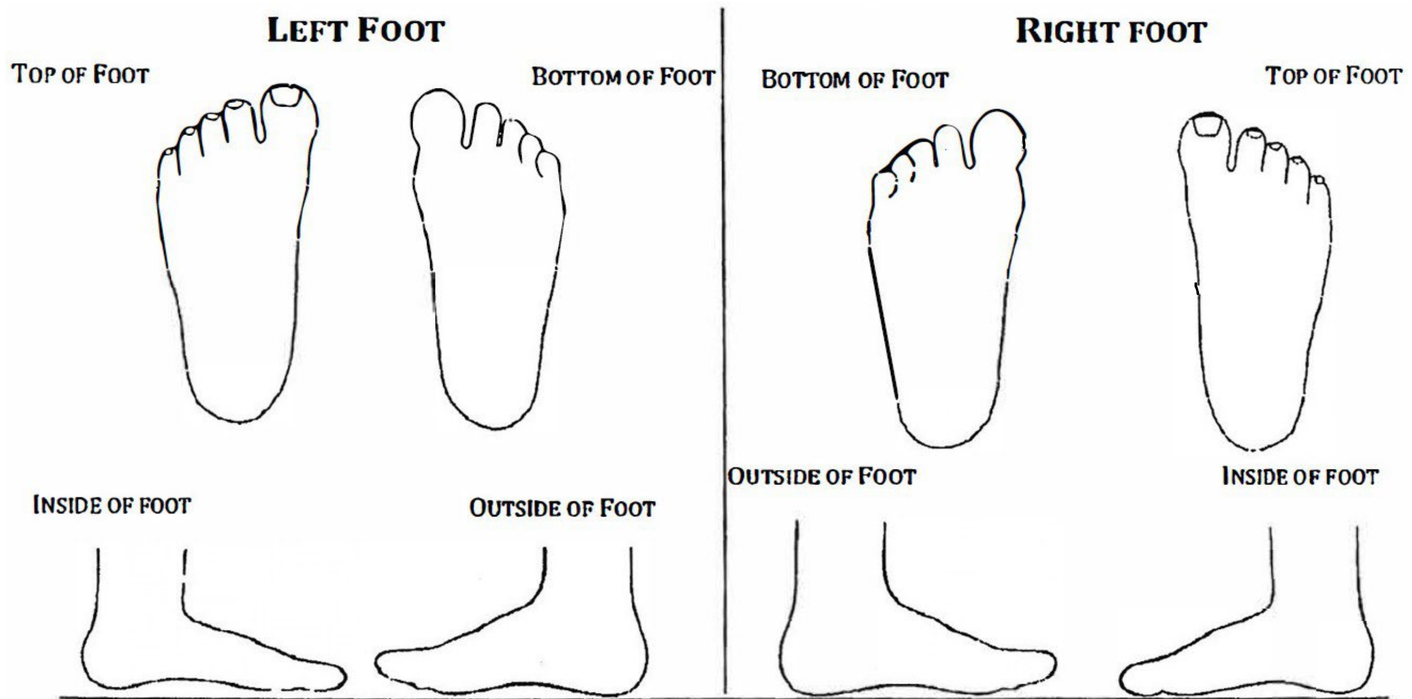
____

____

DO YOUR NAILS OR CALLUSES HURT? ☐ NO ☐YES (IF YES, PLEASE MARK TOE(S) ON IMAGES BELOW)

DO YOU USE BLOOD THINNERS LIKE COUMADIN, ELIQUIS, PLAVIX, ETC? ☐YES:_______________ ☐NO

IF YES, WHICH DOCTOR PRESCRIBES THIS MEDICATION AND WHEN WERE YOU LAST SEEN: ___________________________
DO YOU HAVE POOR BLOOD FLOW, COLD FEET, CRAMPING OR PAINFUL LEGS WHEN WALKING? ☐YES ☐ NO
WHERE IS YOUR TOENAIL/FOOT PAIN LOCATED? *PLEASE MARK ON THE IMAGES BELOW*



THIS PROBLEM: ☐ DEVELOPED ALL OF A SUDDEN ☐GRADUALLY DEVELOPED OVER TIME

☐CAUSED BY AN INJURY (IF SO, PLEASE DESCRIBE): ____

DESCRIBE THE PAIN: ☐NO PAIN ☐SHARP ☐STABBING ☐DULL ☐ACHING ☐BURNING ☐RADIATING ☐ITCHING

☐OTHER: ______________________ RATE YOUR PAIN (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST)

OVER TIME HAS THIS PROBLEM: ☐STAYED THE SAME ☐GETTING WORSE ☐IMPROVED

WHAT MAKES YOUR PROBLEM WORSE? ☐WALKING ☐STANDING ☐DAILY ACTIVITIES ☐RESTING ☐DRESS SHOES ☐HIGH HEELS ☐FLAT SHOES ☐ANY CLOSED TOE/TIGHT SHOE ☐RUNNING/HIKING
☐OTHER ____

WHAT MAKES THE PROBLEM BETTER: ____
WHAT TREATMENTS HAVE YOU TRIED: ☐REST ☐ ICE ☐MASSAGE ☐MEDICATION ________ ☐OTHER__________
WHO ELSE HAVE YOU SEEN FOR THIS PROBLEM: ____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK: ____________________________

MEDICAL HISTORY ***(PLEASE PROVIDE A COPY OF MEDICATION LIST OR OTHER PRE-FILLED FORMS)***

ILLNESSES | PRIOR SURGERIES | DATE

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

MEDICATIONS (INCLUDING PRESCRIBED, OVER THE COUNTER, HERBAL SUPPLEMENTS) ☐***COPY MY MED LIST***

MEDICATION NAME DOSE FREQUENCY PRESCRIBER REASON

____

____

____

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING

☐DIABETES ☐HEART DISEASE ☐CANCER (TYPE) _______ ☐PACEMAKER ☐AFIB
☐BLOOD CLOT/DVT ☐PVD ☐LEG ULCER ☐PHLEBITIS ☐BLEEDING OR CLOTTING DISORDER
☐MIGRAINES ☐ HEPATITIS ☐HIV ☐GOUT ☐RHEMATOID ARTHRITIS ☐OSTEOARTHRITIS ☐ PSORIASIS
☐LYME DISEASE ☐ ANXIETY / DEPRESSION ☐MEMORY LOSS ☐PSYCHIATRIC CONDITION (TYPE)__________

ALLERGIES ☐NONE KNOWN

☐PENICILLIN ☐SULFA ☐KEFLEX ☐CODEINE ☐MORPHINE ☐ASPIRIN ☐NSAIDS ☐ OTHER __________
☐ANESTHESIA REACTION __________________ ☐ FOOD ALLERGY_________________________

☐TAPE ☐LATEX ☐SHELLFISH ☐IODINE ☐OTHER ____

SOCIAL HISTORY MARITAL STATUS ☐SINGLE ☐MARRIED ☐PARTNERED ☐SEPARATED ☐DIVORCED ☐WIDOWED
ALCOHOL USE: ☐NEVER ☐NO LONGER ☐RARE ☐OCCASIONAL / SOCIAL ☐MODERATE
TOBACCO / VAPING: ☐NEVER ☐QUIT – WHEN? ______ ☐OCCASIONAL ☐DAILY ____ PACKS PER DAY
RECREATIONAL DRUGS: TYPE ___________

DO OTHERS DEPEND ON YOU FOR THEIR CARE: ______ CHILDREN (AGES)_____ ☐ELDERLY OR DISABLED FAMILY MEMBER
EXERCISE: ☐NEVER ☐YES BUT NOT CURRENTLY DUE TO INJURY ☐RARE ☐OCCASIONAL ☐WEEKLY ☐DAILY
TYPES OF EXERCISE/SPORTS: ____

EMPLOYER:____________________________ OCCUPATION: ___________________________________

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

ANYTHING ELSE YOU WOULD LIKE US TO KNOW : ____

____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY MEDICAL STATUS, INCLUDING MEDICATIONS.

______________________________________ ______________________________________

PRINT NAME OF PATIENT (OR PARENT OR GUARDIAN) SIGNATURE

______________________________________ ______________________________________

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE