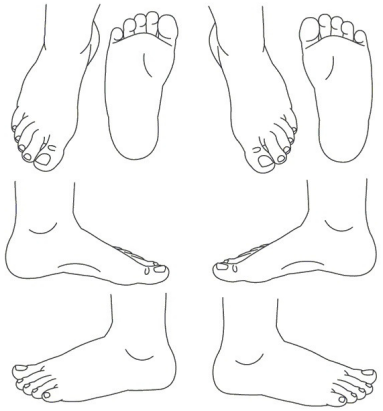
NORTHEAST GEORGIA PODIATRY
PATIENT MEDICAL HISTORY

First	MI	Last	Nickname	Occupation	
Sex: ◯ M ◯ F	Age	Birth Date	Shoe Size	Weight	Height



Please mark the location of your problem(s) or pain on the diagram and number them (i.e. 1, 2). Describe the problem and cause if you know:

_____

_____

_____

Describe type of symptom and associate #:

Aching Pain _____ Shooting Pain _____
Throbbing Pain _____ Tenderness _____
Sharp Pain _____ Dull Pain _____
Burning Pain _____ Tingling _____
Itching _____ Numbness _____
When did the symptoms start?_____
The following (Worsen/Don't Change/Make Better):
Running:_____ Shoe Gear:_____
Walking:_____
Severity (1/Mild to 10/Severe):_____
Condition is: ◯ Improving ◯ Worsening ◯ Unchanged
Timing:

◯ Early Morning ◯ Gradual Onset
◯ Night ◯ Sudden
◯ Throughout the day ◯ With exercise
◯ Near the end of the day ◯ Other:_____

Previous therapies:_____
Current athletic activities:_____
Orthotics: ◯ Yes ◯ No Still Using? ◯ Yes ◯ No
Other Foot Conditions (Please label R/L):

Ingrown nails: ____ Warts: _____ Arch pain:_____
Thick yellow nails: _ Bunions: _____ Heel pain:_____
Foot numbness: __ Leg pain: _____ Ankle pain:_____
Corns/Callouses: __ Hammer toes: _ Other:_____

Medical History:

◯ Anemia ◯ Gout ◯ Lung Disease
◯ Alzheimer's ◯ Heart Attack ◯ Nerve Disorder
◯ Arthritis ◯ Heart Condition ◯ Osteoporosis
◯ Asthma ◯ ↑Blood Pressure ◯ Phlebitis
◯ Back Pain ◯ HIV or AIDS ◯ Poor Circulation
◯ Bleeding Disorder ◯ High Cholesterol ◯ Rheumatic Fever
◯ Cancer ◯ Hepatitis ◯ Stroke
◯ Diabetes 1/2 ◯ Kidney Disease ◯ Stomach Ulcers
◯ Epilepsy ◯ Keloid/Scar ◯ Thyroid Disorder
◯ GERD ◯ Liver Disease ◯ Tuberculosis
◯ Glaucoma ◯ Vascular Disease ◯ Other: _____ _____

Current Health:

◯ Joint implant ◯ Chemotherapy ◯ Slow healing
◯ Heart valve ◯ Excessive bleeding ◯ Other illness:

Surgical History (List all prior surgeries):

_____

Allergies (Describe type of reaction):

◯ Adhesive tape ◯ Novocaine, Lidocaine
◯ Aspirin ◯ Pain medication
◯ Codeine ◯ Penicillin
◯ Demerol ◯ Iodine
◯ Motrin, Advil ◯ Sulfa
◯ Morphine ◯ Other Antibiotic: ____
◯ Other: _____

Medications

Are you taking insulin? ◯ Yes ◯ No
Other medications (include dose):

_____ _____ _____
_____ _____ _____
_____ _____ _____

If additional, please attach list or use back

Social History:

Do you smoke or use tobacco? ◯ Yes ◯ No
Alcoholic beverages:
◯ None ◯ Rare ◯ Moderate ◯ Daily
Recreational Drugs:
◯ None ◯ Rare ◯ Moderate ◯ Daily

Family History:

List relationship of relatives with:

Arthritis: _____ Foot problems: _____
Birth defects: _____ Heart attack: _____
Cancer: _____ ↑Blood Pressure: _____
Diabetes: _____ Stroke: _____