Record ID #	*GULF COAST PODIATRY ▪ Page 1 of 2* *Confidential Office Medical Record*	☐ Only Changes To The Previous History Information Are Noted

1 PATIENT IDENTIFICATION AND CONTACT INFORMATION

Patient Acct #

First Name: MI: Last Name: Your type of Job Activity / Occupation:

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

Last 4 digits of Social Security # | Sex: M / F | Age: | Birth Date: / / | Shoe Size: | Weight: | Height:

☐ Address me by my: ◯ First Name ◯ Nickname:

Phone Numbers For Contacting You:
Day: (________) ________ - ________
Evening: (________) ________ - ________
Cell: (________) ________ - ________

In Case of Emergency, Please Call:
____
Day: (________) ________ - ________
Evening: (________) ________ - ________

Please Provide Your Preferred Pharmacy:
____
Street / City: ________
Day: (________) ________ - ________

☐ INITIAL HISTORY

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 ... then subsides? Y N
Percent of waking hours spent on your feet? 20% 40% 60% 80% 100%
List the sports/type of dance you are active in:
____

Does foot pain limit your desired activities? ☐ Yes ☐ No
Do you have any difficulculty 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 Light Stool ☐ Unexplained Weight Loss
☐ Cancer ☐ Somach 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 illnesses? (*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 hours? (*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 ________ Eating 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 abnnormal bruising, bleeding or scarring? ☐ Yes ☐ No
Do you smoke now? ☐ Yes ☐ No Packs / Day ____ Years ____
Did you ever smoke? ☐ Yes ☐ No Packs / Day ____ Years ____
If you quit, when did you do so? ________
Alcholic beverages? (*cirle 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?
Latex, Adhesive Tape (*circle*)	☐	☐	
Penicillin	☐	☐	
Other Antibiotics (*list below*)	☐	☐	
Empirin, Tylenol (*if yes, circle*)	☐	☐	
Aspirin, Advil, Aleve or Motrin (*cirlce*)	☐	☐	
Celebrex	☐	☐	
Other Pain remedies (*list below*)	☐	☐	
Morphine	☐	☐	
Codeine	☐	☐	
Demerol	☐	☐	
Other Narcotics (*list below*)	☐	☐	
Novocaine	☐	☐	
Other Anesthetics (*list below*)	☐	☐	
Sulfa Drugs	☐	☐	
Shrimp, Lodine or Merthiolate	☐	☐	
Any other drugs or medications	☐	☐	

Others: ________

Anything else that you want to tell the doctor? ☐ Yes ☐ No
Illnesses / Explanations: ________

☐ UPDATE OF HISTORY TAKEN

PATIENT HISTORY AS OF ____ / ____ / ____

PLEASE CONTINUE ON THE OTHER SIDE TO PROVIDE ADDITIONAL DETAILS

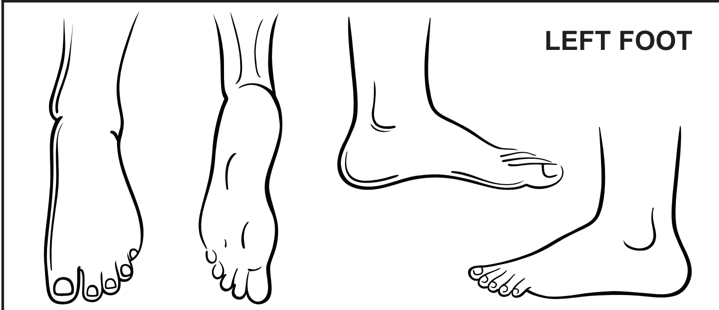
Patient CC# (s)

3 PATIENT'S CURRENT CHIEF COMPLAINS CC / HPI

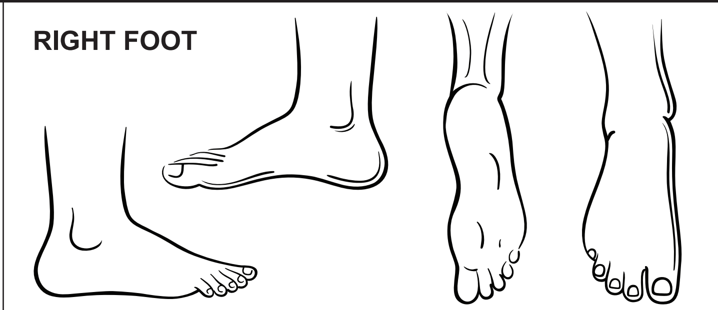
Patient CC# (s)

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

LEFT FOOT



RIGHT FOOT



1 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 1st 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

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

Previous medical treatment(s) or home remedies:
____

2 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 in the box to the right.

My 2nd 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/Discomvort 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

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 COORDINATE YOUR CARE

My:	Physician't Name	Phone Number	City	Date Last Seen	Referred me:	I was sent or came in especially for:		
Family/ Primary				/ /	Y N	2nd Opinion	Surgical Eval	Consult
Specialist				/ /	Y N	2nd Opinion	Surgical Eval	Consult
Other Podiatrist				/ /	Y N	2nd Opinion	Surgical 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

PATIENT HISTORY

___ / ___ / ___

PATIENTS NAME LAST, FIRST, MIDDLE ___

NEDUCAK RECIRD /3 IR LAST 4 DIGITS OF SSN ___

SEX ___ AGE ___ DOB ___ / ___ / ___

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