Podiatric Medical History

Name: Date:

What is your main foot problem today?

History of Present Illness. Briefly answer the following questions.

When did your main problem begin?

Describe any pain and /or disability:
Is the pain Burning Throbbing Sharp Dull Aching Other

What causes the problem or makes it worse?

What make the problem better?

Medical History

- ☐ Heart disease
- ☐ Rheumatoid arthritis
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Vascular disease
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Sciatica
- ☐ Glaucoma
- ☐ Immune disorder
- ☐ Blood disorder
- ☐ Hypertension
- ☐ Lung disease
- ☐ Cancer
- ☐ Stroke
- ☐ Osteoarthritis
- ☐ Phlebits
- ☐ Other

Past major Surgical History (Include dates)

List Medications now taking:

Allergies

- ☐ Penicillin
- ☐ Other Antibiotic
- ☐ Sulfa drugs
- ☐ Iodine
- ☐ Adhesive tape
- ☐ Other
- ☐ Other Antibiotic
- ☐ Codine
- ☐ Asprin
- ☐ Food
- ☐ Chemicals

Family Medical History

- ☐ Heart disease
- ☐ Rheumatoid arthritis
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Cancer
- ☐ Stroke
- ☐ Glaucoma
- ☐ Immune disorder
- ☐ Blood disorder
- ☐ Hypertension
- ☐ Vascular disease
- ☐ Liver disease
- ☐ Phlebits
- ☐ Other

Social History

Tobacco use ☐ No ☐ Yes

Amt: _ Yrs Quit date:

Alcohol use ☐ No ☐ Yes

Amt: Yrs Quit date:

Caffeine use ☐ No ☐ Yes

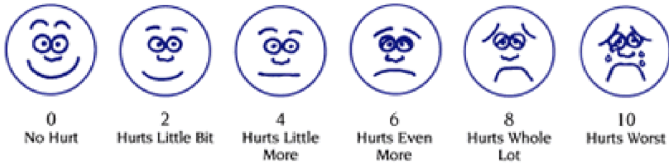
Cups/day:

Marital Status:

Occupation:

Podiatric Medical History

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



From Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P, eds. *Wong's Essentials of Pediatric Nursing.* 5th ed. St. Louis, MO: Mosby; 2001:1301. Reprinted by permission.

Pain Level Current: ____ **/ 10**

Pain related to complaint? ☐ Yes ☐ No ☐ Acute ☐ Chronic

Review of systems

Have you ever had or do you have any of the following ?

Neurological/Eyes Ears Nose Throat:

☐ No Problems ☐ Dizziness ☐ Seizures
☐ Insomnia ☐ Headaches ☐ Vision deficit
☐ Glaucoma ☐ Cataracts ☐ Hearing deficit
☐ Fainting speels ☐ Ear problem ☐ Nose problem
☐ Throat Problem ☐ Numbness ☐ Tingling
☐ Unusual feelings hand / feet ☐ Other

Cardiovascular:

☐ No Problems ☐ Pasmaker ☐ Swelling legs/Ankles
☐ Phlebitis/Clots ☐ Heart failure ☐ Irrigular heart beat
☐ Heart attack ☐ Defibrillator
☐ Peripheral Vascular Disese ☐ Other

Musculo-Sketal:

☐ No Problems ☐ Amuptation ☐ Leg pain at rest
☐ Leg pain walking ☐ Weekness ☐ Paralysis
☐ Hammer toes ☐ History of falls ☐ Bunions
☐ Arthritis ☐ Prosthesis ☐ Sciatica
☐ Other

Gastrointestinal:

☐ No Problems ☐ Nausea ☐ Trouble Chewing
☐ Vomiting ☐ Diarrhea ☐ Trouble Swallowi
☐ Constipation ☐ GERD (Reflux) ☐ Colitis
☐ Black stools ☐ Blood in stools ☐ Chron's
☐ Other

Urinary:

☐ Diaylisis ☐ No Problems ☐ Incontinence
☐ Pain / discomfort ☐ Frequent ☐ Retension
☐ Difficulty Urinating ☐ Other

Respiratory:

☐ No Problems ☐ Asthma ☐ Shortnesss of brea
☐ Labored ☐ Emphysema ☐ Cough
☐ Chronic Obstrutive Pulonary Disease
☐ Other

Skin:

☐ No Problems ☐ Rash ☐ Bruises
☐ Eczema ☐ Foot /leg Ulcers ☐ Psoriasis
☐ Keloid Scars ☐ Defromed nails ☐ Other

Hematological (Blood)

☐ No Problems ☐ Anemia ☐ Jaundice
☐ Cancer ☐ On Coumadin ☐ Taking Asprin
☐ Bleeding disorde ☐ Sickle Cell ☐ Other

Other:

Enter your Weight: ____

Height: ____

Shoe Size: ____

Shoe width: ____

Last date you were seen by your medical doctor? ____

Last Blood Pressure reading: ____

Signature: **Date:**