Reznick, Wolf Podiatry and Associates
Medical information form

Name_________________________________

Describe your foot problem (Give specific location) _____________________________________

____

____

How long has this been bothering you? _____ days _____ weeks _____ months _____ years

Please circle what you feel. You may circle more than one:

Burning Throbbing Sharp Dull Aching Numbness Tingling Shooting

How intense is your pain? 0= none, 10= severe (circle one) 1 2 3 4 5 6 7 8 9 10

What causes the problem or makes it worse? ______________________________________

Are there any other problems associated with your foot complaint? (e.g.; back or leg pain) ____________

____

List previous and current treatments for this condition ____________________________________

____

Do you have any other foot problems that need attention? ________________________________

____

Is this a work injury? Yes No Auto Accident? Yes No Other __________________

ALLERGIES Please check those that apply: ____ No known drug allergies

____ Erythromycin ____ Aspirin _____ Metals _____ Latex _____ Codeine

____ Iodine / dyes ____ Sulfa drugs _____ Morphine _____ Penicillin

_____ Foods __________________ _____ Other ___________________________________

MEDICATIONS (List all medications you take regularly. Include over the counter or non- prescription medications. Please include the dose. If you have a list we would be happy to make a copy.)

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

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HAVE YOU EVER HAD THE FOLLOWING ILLNESSES (CHECK THOSE THAT APPLY)

MAJOR DISEASE:

___ Diabetes
___ High blood pressure
___ Angina (chest pain)
___ Heart Disease
___ Other _________

___ Heart Attack
___ Arrhythmia
___ Murmur
___ Mitral Valve Prolapse
___ Stroke
___ Chest Pain

ARTHRITIS:

___ Osteoarthritis
___ Rheumatoid
___ Gout
___ Fibromyalgia
___ Other _________

VASCULAR:
___ Anemia
___ Sickle Cell
___ Bleeding Disorder
___ Poor Circulation
___ Blood Clots

MISCELLANEOUS:

___ Epilepsy
___ Thyroid Disease
___ Muscle Disease
___ Kidney Disease
Other ___________

___ Bladder Problem
___ Prostate Problems
___ Venereal Disease
___ Skin Conditions
___ Cancer; type _____
___ Hepatitis

RESPIRATORY:
___ Asthma
___ Emphysema
___ Shortness of Breath

GASTROINTESTINAL:
___ GI or Rectal Bleeding
___ Stomach Problems
___ Hiatal Hernia
___ Bowel Disorders
___ Ulcers
___ Acid Reflux

SURGICAL HISTORY: Please list all past operations on any part of your body. (Give dates)

____

____

____

Do you have any artificial joints? Yes No Do you have heart valve implant? Yes No

Do you have mitral valve prolapse? Yes No

FAMILY HISTORY
(CHECK THOSE THAT APPLY for Father (F) and or Mother (M).

__ Diabetes (F) (M)
__ Rheumatoid Arthritis (F) (M)
___ Cancer (F) (M)
___ High blood pressure (F) (M)
___ Heart Disease (F) (M)
___ Thyroid problems (F) (M)

__ Kidney Disorder (F) (M)
__ Respiratory Disease (F) (M)
___ Bleeding Tendencies (F) (M)
___ Nervous Disorder (F) (M)
___ Asthma (F) (M)
___ Stroke (F) (M)

__ Seizures (F) (M)
__ Osteoarthritis (F) (M)
___ Liver Disorder (F) (M)
___ Gout (F) (M)
___ Anemia (F) (M)
___ Sickle Cell Anemia (F) (M)

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SOCIAL HISTORY

Employment: (Y) (N) Occupation:__________________

Smoker: (Y) (N) If yes about how many packs per day _____ How many years: _______
Former smoker: (Y) (N) How many years ago: ______

Drink alcoholic beverages (Y) (N) If yes, amount per week: __________

Review of Symptoms: (circle all that apply or circle None)

Constitutional: None, Weight loss, Weight gain, Fever or chills, Trouble sleeping, Fatigue, Weakness

Eyes: None, Vision loss, Glasses or contacts, Double vision, Tearing, Itchy, trauma

ENMT: None, Headache, Head injury, Decreased hearing, Ear ache, Ringing in ears (tinnitus), Drainage, Nose bleeds, Cough, Sore Throat (longer than 1 week)

Skin: None, Dry skin, Rash, Ulcer, Eczema, Psoriasis, itchy skin, hyperhydrosis (sweat a lot) Blister

Muscle Skeletal: None, Foot pain, Joint pain, Neck pain, back pain, hip pain, knee pain morning stiffness, Weakness

Neurological: None, Numbness, burning, hypersensitive, seizure, uncontrolled movements, tremors, trauma

Urinary: None, Burning urination, dialysis, Frequent urination, Infrequent urination

Endocrine: None, hyperglycemia, hypoglycemia, Frequent thirst, fatigue

Respiratory: None, Asthma, shortness of breath, snoring, cough, chest pain, Chest tightness, Wheezing

Gastric: None, Acid Reflux / heart burn, Abdomen Pain, Blood in Stool, Constipation, Diarrhea, hemorrhoids, Vomiting

Cardiovascular: None Chest pain or discomfort Tightness Shortness of breath

Psychiatric: None depression paranoia addictive tendencies irritability

Fall Assessment: Have you had 2 or more falls in the past year? Yes No