

# PODIATRIC HISTORY

Is there any personal or family history of diabetes?  Yes  No

If yes, your relation to the diabetic: \_\_\_\_\_

Cigarette/Tobacco use -  Yes  No      Packs per day \_\_\_\_\_ Years smoked \_\_\_\_\_

Please indicate which foot problems you now have or have had in the past.

Ankle pain  Yes  No

Athlete's foot  Yes  No

Bunions  Yes  No

Corns & Calluses  Yes  No

Cramps or Numbness in feet or legs  Yes  No

Flat feet  Yes  No

Heel pain  Yes  No

Ingrown toenails  Yes  No

Plantar warts  Yes  No

Swelling in ankles or feet  Yes  No

Tired Feet  Yes  No

## MEDICAL HISTORY

AIDS/HIV  Yes  No

Anemia  Yes  No

Angina  Yes  No

Arthritis  Yes  No

Back problems  Yes  No

Bleeding disorders  Yes  No

Cancer  Yes  No

Circulatory problems  Yes  No

Diabetes  Yes  No

Fainting  Yes  No

Gout  Yes  No

Heart disease  Yes  No

Hemophilia  Yes  No

High blood pressure  Yes  No

Kidney/Liver Problems  Yes  No

Phlebitis  Yes  No

Rash  Yes  No

Stroke  Yes  No

Ulcers  Yes  No

Varicose veins  Yes  No

Thick scars (Keloids)  Yes  No

## MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins.

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## ALLERGIES

Place a mark on "Yes" or "No" to indicate if you are allergic to any of the following.

Aspirin  Yes  No

Codeine  Yes  No

Demerol  Yes  No

Iodine  Yes  No

Local Anesthetics  Yes  No

Other  Yes  No

Penicillin  Yes  No

Other Antibiotics  Yes  No (Please list in margin)

Sulfa  Yes  No

Tetanus  Yes  No

Tape (adhesive)  Yes  No

Latex  Yes  No

## WHAT IS YOUR FOOT OR ANKLE PROBLEM?

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## CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my feet.

\_\_\_\_\_  
*Patient's signature*

\_\_\_\_\_  
*Date*