256 State Road 129 S.
Batesville, IN 47006
Phone: 812.932.4700w

Patient Label

# PODIATRY: PATIENT HISTORY

Patient Name: ____________________ Date of Birth: ____________

Referred By: ____________________ Height: __________ Weight: __________

Primary Care Physician: ____________________ Location: ____________

Cardiologist: ____________________ Location: ____________

Endocrinologist: ____________________ Location: ____________

Pharmacy: ____________________ Location: ____________

Email: ________________________________________

**Review of Systems:** Do you currently have or have you had any of the following:

**General**
- ❒ Fever
- ❒ Feeling well

**Skin**
- ❒ Slow-healing cuts
- ❒ Non-healing ulcer

**Neurological**
- ❒ Tingling in toes
- ❒ Numbness of feet
- ❒ Burning in toes

**Musculoskeletal**
- ❒ Back pain
- ❒ Joint pain
- ❒ Muscle pain
- ❒ Muscle weakness

**Hematologic**
- ❒ Blood clots in legs

**Cardiovascular**
- ❒ Leg cramps
- ❒ Leg swelling

**Medical History:** Do you currently have or have you had any of the following:

- ❒ Diabetes: Type ____________
- ❒ Heart Disease
  - ❒ Pacemaker/Defibrillator
  - ❒ Stents/Bypass
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Other: ____________________
- ❒ Kidney Failure
  - ❒ Dialysis
- ❒ Liver Disease
- ❒ Stroke
- ❒ Anemia
- ❒ Cancer: Type ____________
- ❒ Thyroid Disease
  - ❒ Overactive
  - ❒ Underactive

**Females Only:**
- ❒ Pregnant
- ❒ Nursing

**Allergies:** Please include any reactions you have experienced (itching, swelling, hives, nausea)

- ❒ No Known Allergies
- ❒ Aspirin
- ❒ Barbiturates
- ❒ Cephalosporins
- ❒ Codeine
- ❒ Eggs
- ❒ Iodine
- ❒ Latex
- ❒ Morphine
- ❒ Penicillin
- ❒ Sulfa Drugs
- ❒ Tetracycline
- ❒ Other: ____________________

**Reactions:** ________________________________________

## Surgical History

Have you previously had foot surgery? ❒ Yes ❒ No If yes, please describe below.

Surgical procedure: ______________________________

Surgeon: ______________________ Date of Surgery: ______________

Surgical procedure: ______________________________

Surgeon: ______________________ Date of Surgery: ______________

Have you had any other surgeries? ❒ Yes ❒ No If yes, please describe below.

Surgical procedure: ______________________ Date of Surgery: ______________

Surgical procedure: ______________________ Date of Surgery: ______________

Surgical procedure: ______________________ Date of Surgery: ______________

**Medications (Please list all prescribed and over-the-counter medications, including vitamins/supplements)**

Medication: ______________ Dosage: ________ Frequency: ________

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Medication: ______________ Dosage: ________ Frequency: ________

**Family History (Please check all that apply and indicate the relative(s).)**

❒ High blood pressure Relationship: ______________________

❒ Cancer (Type: ____________) Relationship: ______________________

❒ Heart disease Relationship: ______________________

❒ Diabetes Relationship: ______________________

Any other family problems? ______________________________

**Social History (Please check all that apply and indicate the relative(s).)**

**Tobacco Use**

❒ Never smoked ❒ Current user: ________ packs per day, ________ years of smoking

❒ Former user: ________ packs per day, ________ years of smoking, ________ years since quit

Tobacco use in the home: ❒ Yes ❒ No

**Alcohol Use**

❒ None ❒ Several drinks per day/week/month ❒ Recovered alcoholic ❒ Socially/Occasionally

**Illegal Drug Use**

❒ Never used ❒ Currently using: ______________ ❒ Recovering substance: ______________

Employer: ______________________ Occupation: ______________________

Shoe size: ____________ Amount of time on feet during day/at work: ❒ 10% ❒ 25% ❒ 50% ❒ 100%

**Please list anyone you authorize to receive information about your care:**

Name: ________________ Relationship: ________________ Phone: ____________

Name: ________________ Relationship: ________________ Phone: ____________

Patient/Parent/Guardian Signature: ______________________ Date: ______________