

**ALLENTOWN FAMILY FOOT CARE
PROFESSIONAL CORPORATION
2414 WALBERT AVE, ALLENTOWN, PA 18104
(610) 434-7000 Fax (610) 434-7029**

PATIENT

NAME: _____

PODIATRIC HISTORY

What is the chief complaint for which you
Came to be treated? (Include foot, ankle,
Knee, thigh and hip complaints.)

Your occupation _____

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

Do you Smoke Cigarettes Yes No
Years smoked _____

How often do you drink alcohol < one drink a week 1-5 drinks a week > one drink a week

Have you ever been to a Podiatrist before?
 Yes No
If yes, please list.

Athletic activities in which you participate
(please list and indicate frequent)

Name _____

Last Visit _____

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

I have not had any previous foot problems

Ankle pain	<input type="checkbox"/> Yes	Athlete's Foot	<input type="checkbox"/> Yes
Bunions	<input type="checkbox"/> Yes	Corns and Calluses	<input type="checkbox"/> Yes
Cramps foot/leg	<input type="checkbox"/> Yes	Flat Feet	<input type="checkbox"/> Yes
Numbness feet/legs	<input type="checkbox"/> Yes	Heel Pain	<input type="checkbox"/> Yes
Ingrown toenails	<input type="checkbox"/> Yes	Plantar Warts	<input type="checkbox"/> Yes
Infections feet	<input type="checkbox"/> Yes	Ulcerations	<input type="checkbox"/> Yes
Amputations	<input type="checkbox"/> Yes	Swelling ankles/feet	<input type="checkbox"/> Yes
Other	_____		

Please Turn Over to the Next Page

Patient Name

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:
 I do not have any of the following conditions (including those on the next page)

AIDS/HIV	<input type="checkbox"/> Yes	Anemia	<input type="checkbox"/> Yes
Angina	<input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> Yes	Artificial heart valves	<input type="checkbox"/> Yes
Back Problems	<input type="checkbox"/> Yes	Bleeding disorders	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> Yes	Chemical Dependency	<input type="checkbox"/> Yes
Chest Pain	<input type="checkbox"/> Yes	Chronic diarrhea	<input type="checkbox"/> Yes
Circulatory problems	<input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> Yes
Double/blurred vision	<input type="checkbox"/> Yes	Ear Problems	<input type="checkbox"/> Yes
Epilepsy	<input type="checkbox"/> Yes	Eye Problems	<input type="checkbox"/> Yes
Fainting	<input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> Yes
Gout	<input type="checkbox"/> Yes	Headaches	<input type="checkbox"/> Yes
Heart Disease	<input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> Yes
Hepatitis/Jaundice	<input type="checkbox"/> Yes	Kidney Problems	<input type="checkbox"/> Yes
Liver Disease	<input type="checkbox"/> Yes	Low Blood Pressure	<input type="checkbox"/> Yes
Nervous Problems	<input type="checkbox"/> Yes	Phlebitis	<input type="checkbox"/> Yes
Psychiatric Care	<input type="checkbox"/> Yes	Radiation Therapy	<input type="checkbox"/> Yes
Rash	<input type="checkbox"/> Yes	Respiratory Disease	<input type="checkbox"/> Yes
Rheumatic Fever	<input type="checkbox"/> Yes	Shortness of Breath	<input type="checkbox"/> Yes
Sinus problem	<input type="checkbox"/> Yes	Special Diet	<input type="checkbox"/> Yes
Stroke	<input type="checkbox"/> Yes	Swollen neck glands	<input type="checkbox"/> Yes
Thyroid problems	<input type="checkbox"/> Yes	Tired Feet	<input type="checkbox"/> Yes
Tuberculosis	<input type="checkbox"/> Yes	Urination problems	<input type="checkbox"/> Yes
Varicose Veins	<input type="checkbox"/> Yes	Venereal Disease	<input type="checkbox"/> Yes
Weight Gain	<input type="checkbox"/> Yes	Weight loss, unexplain	<input type="checkbox"/> Yes

MEDICATIONS:

Include prescriptions, over the counter medications, vitamins and herbal medicines:

I have no home medications

Pharmacy Name and Phone

Number: _____

ALLERGIES: Are you allergic to any of the following:

I have no known allergies

Adhesive Tape	<input type="checkbox"/> Yes	Anticoagulant Therapy	<input type="checkbox"/> Yes
Aspirin	<input type="checkbox"/> Yes	Codeine	<input type="checkbox"/> Yes
Iodine	<input type="checkbox"/> Yes	Local Anesthetics	<input type="checkbox"/> Yes
Penicillin	<input type="checkbox"/> Yes	Sulfa	<input type="checkbox"/> Yes
Latex	<input type="checkbox"/> Yes	Other: _____	

Patient Name

PRIOR SURGERIES: (List all surgeries including any foot surgery)

FAMILY HISTORY: (Blood relatives only, not family members related by marriage)

Indicate the disease in the disease column and place a check mark in the family member's column who had the disease.

Disease	Mother	Father	Grandfather (M)	Grandmother (M)	Grandfather (F)	Grandmother (F)	Other:

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY PERMISSION TO THE DOCTOR TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FEET.

Patient Signature: _____

Date: _____