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.

_____

Name_____

_____

Last Visit_____

_____

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

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

[ ] I have not had any previous foot problems

Ankle pain	**[ ] Yes**	**Athlete's Foot**	**[ ] Yes**
Bunions	**[ ] Yes**	**Corns and Calluses**	**[ ] Yes**
Cramps foot/leg	**[ ] Yes**	**Flat Feet**	**[ ] Yes**
Numbness feet/legs	**[ ] Yes**	**Heel Pain**	**[ ] Yes**
Ingrown toenails	**[ ] Yes**	**Plantar Warts**	**[ ] Yes**
Infections feet	**[ ] Yes**	**Ulcerations**	**[ ] Yes**
Amputations	**[ ] Yes**	**Swelling ankles/feet**	**[ ] 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	**[ ] Yes**	**Anemia**	**[ ] Yes**
Angina	**[ ] Yes**	**Arthritis**	**[ ] Yes**
Asthma	**[ ] Yes**	**Artificial heart valves**	**[ ] Yes**
Back Problems	**[ ] Yes**	**Bleeding disorders**	**[ ] Yes**
Cancer	**[ ] Yes**	**Chemical Dependency**	**[ ] Yes**
Chest Pain	**[ ] Yes**	**Chronic diarrhea**	**[ ] Yes**
Circulatory problems	**[ ] Yes**	**Diabetes**	**[ ] Yes**
Double/blurred vision	**[ ] Yes**	**Ear Problems**	**[ ] Yes**
Epilepsy	**[ ] Yes**	**Eye Problems**	**[ ] Yes**
Fainting	**[ ] Yes**	**Glaucoma**	**[ ] Yes**
Gout	**[ ] Yes**	**Headaches**	**[ ] Yes**
Heart Disease	**[ ] Yes**	**High Blood Pressure**	**[ ] Yes**
Hepatitis/Jaundice	**[ ] Yes**	**Kidney Problems**	**[ ] Yes**
Liver Disease	**[ ] Yes**	**Low Blood Pressure**	**[ ] Yes**
Nervous Problems	**[ ] Yes**	**Phlebitis**	**[ ] Yes**
Psychiatric Care	**[ ] Yes**	**Radiation Therapy**	**[ ] Yes**
Rash	**[ ] Yes**	**Respiratory Disease**	**[ ] Yes**
Rheumatic Fever	**[ ] Yes**	**Shortness of Breath**	**[ ] Yes**
Sinus problem	**[ ] Yes**	**Special Diet**	**[ ] Yes**
Stroke	**[ ] Yes**	**Swollen neck glands**	**[ ] Yes**
Thyroid problems	**[ ] Yes**	**Tired Feet**	**[ ] Yes**
Tuberculosis	**[ ] Yes**	**Urination problems**	**[ ] Yes**
Varicose Veins	**[ ] Yes**	**Venereal Disease**	**[ ] Yes**
Weight Gain	**[ ] Yes**	**Weight loss, unexplain**	**[ ] 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	**[ ] Yes**	**Anticoagulant Therapy**	**[ ] Yes**
Aspirin	**[ ] Yes**	**Codeine**	**[ ] Yes**
Iodine	**[ ] Yes**	**Local Anesthetics**	**[ ] Yes**
Penicillin	**[ ] Yes**	**Sulfa**	**[ ] Yes**
Latex	**[ ] 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:_____