Please describe you foot problem: _____

Specify where the problem is: Left Right Both details: _____
How long have you had this problem: _____
On scale of 1-10 (1 = no pain, 10 = worse pain) rate your pain or discomfort: _____
Describe what you are feeling: (check all that apply)

- ☐ Aching
- ☐ Burning
- ☐ Constant
- ☐ Constricting
- ☐ Cramping
- ☐ Dull
- ☐ Gnawing
- ☐ Off and on
- ☐ Pricking
- ☐ Sharp
- ☐ Squeezing
- ☐ Stabbing
- ☐ Throbbing
- ☐ Worse in morning
- ☐ Worse at night
- ☐ Other: _____

Does pain radiate: Y N If yes, where: _____
Anything help relieve condition? _____
What makes it worse? _____
Have you tried any products/treatments? Y N If yes, list: _____
Describe any past problems, injuries, trauma, or shoe change: _____

Weight: _____ **Height:** _____ **Shoe Size:** ____ **Primary Physician:** _____ **LAST VISIT:** _____
Allergies to Medications: Y N if yes, list: _____
List or provide list of current medications: _____

REVIEW OF SYSTEMS: ***(check all that apply)***

General:
- ☐ weight gain
- ☐ weight loss
- ☐ nausea
- ☐ vomiting
- ☐ fever
- ☐ chills

Skin:
- ☐ rash
- ☐ infections
- ☐ lumps
- ☐ dryness

Eyes:
- ☐ legal blindess
- ☐ cataracts
- ☐ glaucoma
- ☐ macular degen.

Ears:
- ☐ deaf
- ☐ hearing loss
- ☐ infections
- ☐ ringing

Respiratory:
- ☐ frequent colds
- ☐ sinus problems
- ☐ asthma
- ☐ pneumonia

Cardiac:
- ☐ chest pain
- ☐ short of breath
- ☐ high blood pres.
- ☐ swelling/edema

Intestinal:
- ☐ pain
- ☐ heartburn
- ☐ constipation
- ☐ diarrhea

Urinary:
- ☐ pain w/urination
- ☐ kidney stones
- ☐ infections
- ☐ incontinence

Musculoskeletal:
- ☐ cramps
- ☐ joint pain/aches
- ☐ fatigue
- ☐ stiffness
- ☐ arthritis
- ☐ gout

Vascular:
- ☐ varicose veins
- ☐ night cramps
- ☐ leg cramps

Neurologic:
- ☐ seizures
- ☐ dizziness
- ☐ numbness
- ☐ tingling
- ☐ loss of balance
- ☐ headaches

Psychiatric:
- ☐ anxiety
- ☐ depression
- ☐ difficulty sleeping
- ☐ dementia

Endocrine:
- ☐ heat/cold intolerance
- ☐ diabetes
- ☐ thyroid imbalance
- ☐ hormone imbalance

Hematologic:
- ☐ bruise easily
- ☐ bleed easily
- ☐ anemic

Feet:
- ☐ nail changes
- ☐ ingrown nails
- ☐ ulcerations
- ☐ tingling
- ☐ numbness
- ☐ calluses

Fall Risk Evaluation:
- ☐ Have you fallen more than two times in the last year?
- ☐ Did any fall require medical attention?

Have you received:
- ☐ Pneumonia vaccination
- ☐ Flu vaccination

MEDICAL HISTORY: (check all that apply)
- ☐ Diabetes
- ☐ Atrial Fibrillation
- ☐ Heart Attack
- ☐ Stroke
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Cancer type:
- ☐ Artificial joints: Knee: L R Hip: L R
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Rheumatic Fever
- ☐ MRSA

List any major surgeries, illnesses, treatments:

Assistive Devices: cane wheelchair walker
Oxygen hearing aides Other:

FAMILY HISTORY:
Family history of : (circle) Diabetes Cancer (type:) Rheumatoid Arthritis Heart problems
Father Living Y N Mother Living Y N

SOCIAL HISTORY:
Marital Status: Single Married (spouse name:) Divorced Widowed Other:
Smoking: Never Former Current: daily _____# packs per day/week/month
Alcohol: Never Socially Frequently Daily _____# of drinks per day/week/month
History of Alcoholism: Y N
Illegal Drugs: Never Formerly Rarely Moderately Daily Drug Type:_____
Employment: Full time Part time Retired Disabled Unemployed
Occupation: Mostly: sit stand