

**Podiatry Associates of Wausau, S.C.**  
**PATIENT MEDICAL HISTORY**

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

**CHIEF CONCERN**

Please describe your current foot problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Describe the onset:  Sudden  Gradual    Since onset the problem has  Worsened  Improved  Not changed

Describe any previous treatments for your current problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever been DIAGNOSED with any of the following:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Claustrophobia                             | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> AIDS                  | <input type="checkbox"/> Depression                                 | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Angina                | <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Sickle Cell       |
| <input type="checkbox"/> Anxiety Disorders     | <input type="checkbox"/> Emphysema                                  | <input type="checkbox"/> HIV                    | <input type="checkbox"/> Stomach Ulcers    |
| <input type="checkbox"/> Arthritis, Osteo      | <input type="checkbox"/> Fibromyalgia                               | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Arthritis, Rheumatoid | <input type="checkbox"/> Gastro-Esophageal<br>Reflux Disease (GERD) | <input type="checkbox"/> Kidney Stones          | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Gout                                       | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Bleeding Disorder     | <input type="checkbox"/> Heart Arrhythmia                           | <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> Varicose Veins    |
| <input type="checkbox"/> Blood Clots           | <input type="checkbox"/> Heart Attack                               | <input type="checkbox"/> Migraine Headaches     | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Cancer _____          |   | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Other _____       |

NONE APPLY

**MEDICATIONS AND ALLERGIES**

**Medications** (Please list all current prescription and over the counter medications):  NONE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:**  Adhesive Tape     Aspirin     Codeine     Iodine     Latex     Local Anesthetic  
 Malignant Hyperthermia     Metal     Penicillin     Sulfa     Other \_\_\_\_\_  
Reactions \_\_\_\_\_

NO KNOWN ALLERGIES

**SURGERIES / INJURIES**

List *all* past surgeries (not limited to feet) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List past injuries \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

NONE APPLY

**REVIEW OF SYSTEMS**

Please check all that apply to your **current** state of health:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Nose Bleeds      | <input type="checkbox"/> Respiratory Infection |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Shortness of Breath   |
| <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Skin Problems         |
| <input type="checkbox"/> Chronic Cough          | <input type="checkbox"/> Joint Pain          | <input type="checkbox"/> Poor Vision      | <input type="checkbox"/> Sore Throat           |
| <input type="checkbox"/> Difficulty Breathing   | <input type="checkbox"/> Leg Cramps          | <input type="checkbox"/> Pregnant         | <input type="checkbox"/> Tendinitis            |
| <input type="checkbox"/> Difficulty Walking     | <input type="checkbox"/> Muscle Pain         | <input type="checkbox"/> Rashes           | <input type="checkbox"/> Weight Gain           |
| <input type="checkbox"/> Frequent Urination     | <input type="checkbox"/> Night Sweats        | <input type="checkbox"/> Recent Fever     | <input type="checkbox"/> Weight Loss           |
| <input type="checkbox"/> Other _____            | <input type="checkbox"/> Other _____         | <input type="checkbox"/> Other _____      | <input type="checkbox"/> Other _____           |

NONE APPLY

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Do you smoke?  No  Yes \_\_\_\_\_

Do you drink alcohol?  No  Yes Frequency: Occasionally/Frequently/Rarely  
packs per day  
(Circle One)

When was your last tetanus booster?  1-5 yrs ago  5-10 yrs ago  > 10 yrs ago  unknown

**PODIATRIC MEDICAL HISTORY**

Have you ever been to a Podiatrist before?  No  Yes \_\_\_\_\_  
Name of previous podiatrist if not in our clinic

Does your family have a history of diabetes?  No  Yes \_\_\_\_\_  
Relationship to you

Does your family have a history of foot problems?  No  Yes \_\_\_\_\_  
Please list types of problems & relationship

**Have you ever experienced any of the following problems with your FEET:**

- |                                   |                                   |                                   |                                   |   |                                      |
|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Coldness | <input type="checkbox"/> Cramping | <input type="checkbox"/> Dryness  | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Itchiness   |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Pain     | <input type="checkbox"/> Redness  | <input type="checkbox"/> Swelling | <input type="checkbox"/> Ulcers             | <input type="checkbox"/> Weakness    |
|                                   |                                   |                                   |                                   |   | <input type="checkbox"/> Other _____ |

NONE APPLY