

**FEITZ FOOT CLINIC, PA**

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*Physicians and Surgeons of the Foot and Leg*

Thank you for choosing our office! This information is important for our records and your health.

**Dr. Use  
Only**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Male/Female DOB: \_\_\_\_\_  
(Last) (M) (First) (Circle)

Are you a diabetic? (circle) Yes or No If yes, are you treated with: insulin, pills, diet?

**CCI  
HPI**

If yes, how many years have you been a diabetic? \_\_\_\_\_ Average blood sugar: \_\_\_\_\_

What is your main foot problem today? \_\_\_\_\_

Where is your pain or problem located? \_\_\_\_\_

How severe is the pain or problem? (circle) none minimal moderate severe Other: \_\_\_\_\_

How long have you had this problem? (circle) 1 2 3 4 5 6 7 8 9 \_\_\_\_\_ days, weeks, months, years?

**Past**

When is the problem worse? (circle) first out of bed, AM, PM, during/after work. Other: \_\_\_\_\_

How would you describe this pain? (circle) shooting, burning, aching, throbbing, bruised, sharp, dull, itching, numbness, dull pain, tenderness. Other: \_\_\_\_\_

What makes it better? \_\_\_\_\_

What caused the problem or makes it worse? \_\_\_\_\_

How has it been treated? (circle) ice, rest, pads, advil, tylenol. Other: \_\_\_\_\_

Do you have any other foot problems that need attention? \_\_\_\_\_

Allergies: (circle) No known allergies, penicillin, sulfa, aspirin, tape, codeine, iodine, novocaine.

List others: \_\_\_\_\_

List all medications: None or: \_\_\_\_\_

List all major Injuries: None or: \_\_\_\_\_

List all major Illnesses: None or : \_\_\_\_\_

Patient Name: \_\_\_\_\_

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Only**

List all surgeries or hospitalizations: None or: \_\_\_\_\_

Is there a family history of these diseases? (circle) diabetes, arthritis, sickle cell, foot problems, heart or lung problems, cancer, keloid scars. Other: \_\_\_\_\_

**Fam**  
\_\_\_\_\_

Social History: Are you (circle) single, divorced, married, widowed, other.

What is your employment? \_\_\_\_\_

Do you smoke? Y/N How much per day? \_\_\_\_ How many years? \_\_\_\_\_ Quit When? \_\_\_\_

Do you drink alcoholic beverages? Yes/No How much per week? \_\_\_\_\_

Do you exercise regularly? Yes/No Type of exercise? \_\_\_\_\_

Women: Number of Children \_\_\_\_ Are you pregnant? Yes/No # of months pregnant? \_\_\_\_

Please circle any symptoms or diseases that apply to you:

Constitutional (general health): weight loss weight gain fever chills fatigue nausea

Height: \_\_\_\_ Weight: \_\_\_\_ Other: \_\_\_\_\_

Eyes/ears/nose/throat: glaucoma dizzy spells fainting spells impaired sight Other: \_\_\_\_\_

Gastrointestinal: ulcers stomach trouble weight loss liver problems hepatitis excessive thirst/hunger nausea vomiting alcoholism diarrhea bloody stools indigestion Other: \_\_\_\_\_

Genitourinary: kidney disease prostate problems excessive urination kidney stones

Other: \_\_\_\_\_

Nervous: numbness tingling burning stroke weakness loss of feeling convulsions seizure

fainting spine disease brain disease paralysis cold feet sciatica Other: \_\_\_\_\_

Cardiovascular: leg cramps varicose veins feet swell chest pain heart attack high blood pressure

leg pain when walking blood clots in legs bypass surgery on legs bad leg circulation phlebitis

mitral valve prolapse heart surgery rheumatic fever chest pain/angina artificial valve pacemaker

Other: \_\_\_\_\_

Derm: skin itching rash deformed nails psoriasis ulcerations eczema athletes foot abrasions

Hives keloid scars Other: \_\_\_\_\_

Mus-ske: gout rheumatoid arthritis stiffness bursitis muscle pain club foot fractures sprains

sciatica back pain joint pain osteoporosis fibromyalgia Other: \_\_\_\_\_

Resp: asthma pneumonia emphysema bronchitis lung problems wheezing coughing

sleep apnea shortness of breath tuberculosis Other: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Endocrine: Diabetes thyroid problems Other: \_\_\_\_\_

Hematologic/Immune: anemia take coumadin plavix aspirin bleeding disorder sickle cell disease  
AIDS HIV+ hepatitis chronic fatigue syndrome on chemotherapy Other: \_\_\_\_\_

Psychiatric: depression nervousness sleeping difficulty seizures mental illness Other: \_\_\_\_\_

Who is your primary physician? \_\_\_\_\_

Did your physician refer you to our office ? Yes or No

When did you last see your doctor? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If Patient Minor Guadian Signature: \_\_\_\_\_ Date: \_\_\_\_\_