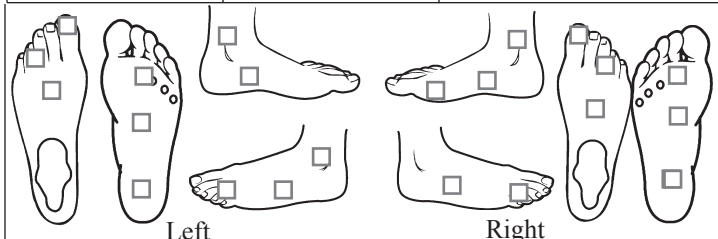


**ATLANTA PODIATRY, PATIENT INFORMATION**

First	Mi	Last	Name Prefer	Occupation	Today's Date
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	Birth Date	Shoe Size	Weight	Height



Please mark the location of your problem(s) or pain **on the diagram** and **number** them (i.e. 1, 2 ect.) Describe the problem below and the cause if you know. \_\_\_\_\_

**Medical History:** Do you have or have you ever been treated for

<input type="checkbox"/> Anemia	<input type="checkbox"/> Gout	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Nerve disorders
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Back Pain	<input type="checkbox"/> HIV +AIDS	<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Hi Cholesterol	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes <input type="checkbox"/> 1 or <input type="checkbox"/> 2	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Keloid/Scar	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> GERD	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> None of these

Other \_\_\_\_\_

Have you had surgery?  Yes  No

Surgery For & Date \_\_\_\_\_

Describe type of symptom and associate # from diagram.

<input type="checkbox"/> Shooting Pain _____	<input type="checkbox"/> Aching pain _____
<input type="checkbox"/> Throbbing Pain _____	<input type="checkbox"/> Tenderness _____
<input type="checkbox"/> Sharp Pain _____	<input type="checkbox"/> Dull pain _____
<input type="checkbox"/> Burning Pain _____	<input type="checkbox"/> Tingling _____
<input type="checkbox"/> Itching _____	<input type="checkbox"/> Numbness _____

When did the symptoms start? \_\_\_\_\_

Walking and / or  Running:  Improves condition

Worsens Condition  Doesn't change condition

Shoe Gear:  Improves  worsens  Dosen't Change / Condition

Severity:  Mild  Moderate  Severe

The Condition is:  improving  worsening  unchanged

Timing of symptoms:

<input type="checkbox"/> Early morning pain	<input type="checkbox"/> Gradual onset
<input type="checkbox"/> Primarily at night	<input type="checkbox"/> Sudden
<input type="checkbox"/> Throughout the day	<input type="checkbox"/> With Exercise
<input type="checkbox"/> Toward end of day	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other _____	

Previous medical treatment(s) or home remedies: \_\_\_\_\_

Please list the athletic activities in which you are involved :

Do you now wear or have you previously worn:

Orthotics?  Yes  No      Still in use?  Yes  No

What other foot or leg problems do you have?

<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both
<input type="checkbox"/> Ingrown Nails	<input type="checkbox"/> Warts	
<input type="checkbox"/> Thick yellow nails	<input type="checkbox"/> Foot Numbness	
<input type="checkbox"/> Corns\callouses	<input type="checkbox"/> Arch pain	
<input type="checkbox"/> Bunions	<input type="checkbox"/> Heel Pain	
<input type="checkbox"/> Hammer toes	<input type="checkbox"/> Ankle Pain	
<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Other: _____	

**ALLERGIES:** Please check the medications that you are allergic to and the type of reaction that you get.  None

<input type="checkbox"/> Adhesive tape	<input type="checkbox"/> Novocaine
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Pain medications
<input type="checkbox"/> Codeine_	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Demerol_	<input type="checkbox"/> Shrimp, Iodine
<input type="checkbox"/> Motrin, Advil	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Morphine	<input type="checkbox"/> Other Antibiotics
<input type="checkbox"/> Others: _____	

**Medications:**

Are you taking Insulin?  Yes  No

Are you taking any other medications?  Yes  No

Medications & Dose: (list or attach) \_\_\_\_\_

**Social History:**

Do you smoke now or use tobacco?  Yes  No

Alcoholic beverages?  None  Rarely  Moderately  Daily

Recreational Drugs?  None  Rarely  Moderately  Daily

**Family History:**

List relationship to you of blood relatives who have had:

Arthritis _____	Foot Problems _____
Birth Defects _____	Heart Attack _____
Cancer _____	High Blood Pressure _____
Diabetes _____	Stroke _____

**Current Health:**

Do you have joint implants?  Yes  No

Do you have artificial heart valves?  Yes  No

Are you under chemotherapy?  Yes  No

Have you had any other serious illness?  Yes  No

Any abnormal bruising, bleeding or scarring?  Yes  No

Are you slow to heal after cuts?  Yes  No

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