

DATE _____

medications

What is the reason for your visit today? _____

How long has this bothered you? _____ days _____ weeks _____ months _____ years

medical history

Yes No Have you had any past problems with your feet or ankles?

If yes, please describe _____

Shoe size _____ Height _____ Weight _____

Are you allergic or sensitive to

Penicillin Sulfa Tape Latex Betadine (*iodine*) Aspirin NONE
 Tylenol™ Ibuprofen Vicodin Codeine Other (*specify*) _____

Please indicate if you have a problem with any of the following

Alcoholism Blood disorders Gout Liver Sleep apnea
 Allergies Breathing problems Heart disease Musculoskeletal Stomach/bowel
 Arthritis (*specify*) _____ Circulation problems Heart murmur Neurological (*specify*) _____ Thyroid (*specify*) _____
 Asthma Depression/anxiety/mental illness High blood pressure _____
 Blood clot/DVT/PE Diabetes High cholesterol Skin disorders (*specify*) _____ Other (*specify*) _____
 Kidney _____

Yes No Are you pregnant? Yes No Are you nursing?

Yes No Have you ever had any surgical procedures on foot/ankle or anywhere else on your body?
If yes, please describe _____

Yes No Do you have any artificial joints? Where? _____

Yes No Do you have an artificial heart valve? _____

family history

Is there any family history (*blood relative*) of
Please indicate

Arthritis _____ Type _____ Cancer _____ Type _____ Flatfeet _____ Neurological _____
 Bleeding disorders _____ Circulation problems _____ Hammer toes _____ Strokes _____
 Blood clot/DVT/PE _____ Diabetes _____ Heart disease _____ Other (*specify*) _____
 Bunions _____

How did you find out about DuPage Medical Group Podiatry?

Physician referral Dr. _____ Internet Telephone book Family member Friend Other _____

social history

Marital status: single married widowed divorced

Yes No Do you smoke? If yes: 1/2 ppd 1 ppd 1 1/2 ppd 2 ppd

Did you smoke in the past? Yes No How many years did you smoke? _____

Yes No Do you drink alcohol? If yes: Socially 1 daily 2 daily >2 daily

Occupation or grade in school: _____

Do you stand or sit at work? _____

What athletic activities do you participate in? _____

physician use only

constitution WD WNL Malnutrition Obese Poor hygiene

gait Normal Antalgic Apropulsive Prolonged DLS Other _____

SENSORIUM

	sharp	dull	vibratory	proprioception	babinski	achilles reflex	patellar ref.
right							
left							

VASCULAR

	DP	PT	CFT	edema	pitting	brawny	varicosities
right							
left							

skin (check all that apply)

- Atrophic Normal
- Cold Pre-ulcerative
- Color changes Ulceration
- Hair growth Warm

ulcer/lesion description (mark location & size)

musculoskeletal

Subluxation of 1st MPJ (*hallux valgus*), 2nd, 3rd, 4th, 5th MPJ 2nd, 3rd, 4th, 5th, DIPJ (*mallet toe*)
 1st PIPJ (*h intrphal*), 2nd, 3rd, 4th, 5th PIPJ (*HDS*)

Pain Pain free with range of motion of digits: 1, 2, 3, 4, 5

Muscle strength _____ /5dorsiflex _____ /plantar _____ /5supinat _____ /5pronator

High arch Low arch Normal arch X-ray findings (*see progress note or x-ray report*)

Additional findings/Diagnosis _____

