PODIATRY PATIENT HISTORY

Allergies (food, medicine, latex, anesthetics, or other):	Medications you take now:
Have you seen a podiatrist before? ☐ Yes ☐ No Last visit: Name:	Shoe size:

1. PODIATRY HISTORY

Foot and ankle problems

Ankle pain ☐ Yes ☐ No
Corns or calluses ☐ Yes ☐ No
Arch problems ☐ Yes ☐ No
Heel pain ☐ Yes ☐ No
Plantar warts ☐ Yes ☐ No
Athlete's foot ☐ Yes ☐ No
Cramps or numbness ☐ Yes ☐ No
Gout ☐ Yes ☐ No
Ingrown toenails ☐ Yes ☐ No
Swelling in feet/ankles ☐ Yes ☐ No
Varicose veins ☐ Yes ☐ No
Circulation problems ☐ Yes ☐ No
Neuropathy ☐ Yes ☐ No

Other foot or ankle problems:

2. MEDICAL HISTORY

AIDS/HIV ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Artificial joints ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Back problems ☐ Yes ☐ No
Bleeding/Clotting disorder ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No Last A1C: _____
Ear problems ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Eye problems ☐ Yes ☐ No
Fainting ☐ Yes ☐ No
Heart disease ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
High/Low blood pressure ☐ Yes ☐ No
Kidney problems ☐ Yes ☐ No
Liver disease ☐ Yes ☐ No
Respiratory disease ☐ Yes ☐ No
Shortness of breath ☐ Yes ☐ No
Stroke ☐ Yes ☐ No

Other medical history:

3. SURGICAL & SOCIAL HISTORY

Previous surgeries or operations:

Alcohol use: ☐ Yes ☐ No
Cigarette or tobacco use: ☐ Yes ☐ No
Drug use: ☐ Yes ☐ No
Family doctor's name:
Last visit date (if known):
Height: Current weight:

Are you under treatment by a doctor for any condition we are not aware of:

☐ Yes ☐ No

If yes, explain:

Pharmacy name:

Pharmacy phone:

PLEASE READ: I authorize Dr. Mattia and authorized staff to provide podiatry care and to share information needed to process insurance claims. I understand I am responsible for charges and fees not paid by insurance. I have read and understand the office privacy policy and agree to these terms.

Patient, parent, or legal representative signature:	Date:
