

**ADVANCED FOOT AND ANKLE CARE
HISTORY AND PHYSICAL**

completed by clinic staff

Name: _____ Male Female

Date: _____

Age: _____ Height: _____ Weight: _____

BP: _____
P: _____
T: _____
R: _____

- Chief foot complaint:**
- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Ingrown toenail | <input type="checkbox"/> Corns | <input type="checkbox"/> Athletes Foot | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Callous | <input type="checkbox"/> Gout | <input type="checkbox"/> Bone or Joint Deformities |
| <input type="checkbox"/> Warts | <input type="checkbox"/> Nail Problems | <input type="checkbox"/> Injury | <input type="checkbox"/> Fungus |
| <input type="checkbox"/> Swollen Ankle | <input type="checkbox"/> Ankle Sprain | <input type="checkbox"/> Ankle popping | |
| <input type="checkbox"/> _____ | | | |

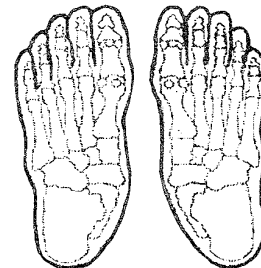
- Signs & Symptoms:**
- | | | | | |
|-----------------------------------|-----------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Numbness | <input type="checkbox"/> Pale toes or feet | <input type="checkbox"/> Lump | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Tingling | <input type="checkbox"/> White toes or feet | <input type="checkbox"/> Thickening | <input type="checkbox"/> Skin Changes |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Stinging | <input type="checkbox"/> Blue toes or feet | <input type="checkbox"/> Soreness | |
| <input type="checkbox"/> Growth | <input type="checkbox"/> Bump | <input type="checkbox"/> Cold toes or feet | <input type="checkbox"/> Toes bend in odd direction | |
| <input type="checkbox"/> _____ | | | | |

- How did this happen?**
- | | | |
|---|---|---|
| <input type="checkbox"/> Trauma to area | <input type="checkbox"/> Improper shoe gear | <input type="checkbox"/> Exposure to fungus |
| <input type="checkbox"/> Gradual onset | <input type="checkbox"/> Work Injury | <input type="checkbox"/> _____ |

How Long has this been going on: _____ Days _____ Weeks _____ Months _____ Years

- Where is condition located:**
- | |
|---|
| <input type="checkbox"/> Left Foot |
| <input type="checkbox"/> Right Foot |
| <input type="checkbox"/> Heel |
| <input type="checkbox"/> Ankle: Inside or Outside |

(Please mark location below)



Left Right

Have you had an MRI: Y or N

Medical Problems:

- | Y | N | Y | N | Y | N | Y | N | Y | N | | | | | | | |
|--------------------------|--------------------------|-----------|--------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Gout | <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Family History of Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramps/Numbness Ft/Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Circulation | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Liver |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Phlebitis | <input type="checkbox"/> | <input type="checkbox"/> | Kidney | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Aids | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Cholesterol |
| | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Smoker | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Notes (comments) regarding "Yes" answers to above: (example: diabetes under control)

Have you had a circulation test? Y or N

If yes, when: _____

Other current health conditions: _____

Present Medications:

Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____

Allergies:

Y N **Y N** **Y N** **Y N**
 Novocain Erythromycin Penicillin Cortisone Other _____
 Codeine Adhesive Tape Sulfa Eggs
 Iodine Tetracycline Aspirin Foods

If "Yes" to any of above, reaction had: _____

Other Operations or Injuries:

Type: _____ Year of Surgery: _____ Hospital: _____ Complications: **Y N** _____
Type: _____ Year of Surgery: _____ Hospital: _____ Complications: **Y N** _____
Type: _____ Year of Surgery: _____ Hospital: _____ Complications: **Y N** _____
Type: _____ Year of Surgery: _____ Hospital: _____ Complications: **Y N** _____

Addiction to alcohol: **Y N** if yes explain: _____
Addiction to drugs: **Y N** if yes explain: _____

Social: Smoke **Y N** Have you ever smoked? **Y N** How Much: _____ How Long: _____
Alcohol **Y N** How much daily/weekly; _____ How many years: _____
Pop **Y N** How much daily/weekly; _____
Coffee **Y N** How much daily/weekly; _____
Tea **Y N** How much daily/weekly; _____

Family History: Mother: **Living** _____ Age _____ in good health _____
Deceased _____ Age _____ cause _____
Father: **Living** _____ Age _____ in good health _____
Deceased _____ Age _____ cause _____

Clinician's Initials _____