

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

Name: \_\_\_\_\_  Male  Female

Date: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

completed by clinic staff

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"/> _____           |  |  |  |

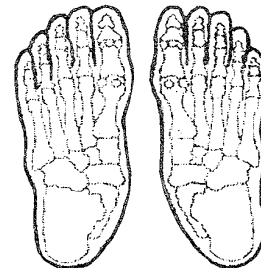
- Signs & Symptoms:**
- |                                   |                                   |   |   |                                       |
|-----------------------------------|-----------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Burning  | <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:**

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

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

Date: \_\_\_\_\_

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 \_\_\_\_\_