

Paradise Podiatry Group
Robert M. Victor, DPM, FACFAS

Patient Name: _____

Date: _____

Reason for being seen: _____

How long have you been bothered by the above? _____

What have you done for your foot problem? _____

Type of pain (circle all that apply): sharp, dull, aching, throbbing, burning, shooting,
 continuous, intermittent, localized, other: _____

Have you ever had, or been treated for, any of the following?

Major Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Angina (Chest pain) <input type="checkbox"/> Heart Disease <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Stroke <input type="checkbox"/> High Cholesterol Gastrointestinal <input type="checkbox"/> Acid Reflux <input type="checkbox"/> GI or Rectal Bleeding <input type="checkbox"/> Bowel Disorders <input type="checkbox"/> Hernia <input type="checkbox"/> Ulcers	Vascular <input type="checkbox"/> Anemia <input type="checkbox"/> Leg Pain When Walking <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Blood Clots <input type="checkbox"/> Poor Circulation Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis Arthritis <input type="checkbox"/> Artificial Joints <input type="checkbox"/> Gout <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Fibromyalgia	HEENT <input type="checkbox"/> Glaucoma <input type="checkbox"/> Headaches <input type="checkbox"/> Hearing Loss Miscellaneous <input type="checkbox"/> Bladder Problem <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Hepatitis/Liver Disease <input type="checkbox"/> Fainting <input type="checkbox"/> Epilepsy/Seizure <input type="checkbox"/> HIV <input type="checkbox"/> Kidney Problem <input type="checkbox"/> Muscle Disease <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Thyroid Disease	Psychological <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Alcohol Dependence <input type="checkbox"/> Drug Dependence Other Medical Problems <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ Family History <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Anesthesia Complications <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer
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Are you taking medications? (please list below or attach a copy)

What operations have you had? _____

Allergies:

<input type="checkbox"/> Penicillin Reaction? _____	<input type="checkbox"/> Sulfa Drugs Reaction? _____	<input type="checkbox"/> Codeine: Reaction? _____
<input type="checkbox"/> Latex: Reaction? _____	<input type="checkbox"/> Adhesive Tape: Reaction? _____	<input type="checkbox"/> Novocaine/Local Anesthetic: Reaction? _____
<input type="checkbox"/> General Anesthesia Reaction? _____	<input type="checkbox"/> NSAIDS: Reaction? _____	Others (Name/Reaction)

Do you smoke? yes no If yes, _____packs per day OR Previous Smoker (Quit Date _____)

Do you drink? yes no If yes, _____drinks per day

(Women) Are you pregnant? yes no Breastfeeding? yes no