Podiatric History

What is the chief complaint for which you came to be treated?

_____

Have you ever been to a podiatrist before? **Yes** **No**
If yes, please list.
Name_____
Last Visit_____

Please indicate which problems you now have or have had in the past.
Circle all that apply

Ankle Pain
Foot Pain
Athlete's foot
Bunions / Hammertoes
Corns / Calluses
Numbness of Legs or Feet
Heel Pain
Ingrown toenails
Plantar Wart
Cramps of Legs or Feet
Flat Feet
Swelling of Ankles or Feet

Medications
Include prescriptions, over-the-counter medications and vitamins

_____

Allergies:

__Penicillin
__Narcotic Agent
__Sulfa Drugs
__Other:_____
__Cephalosporin
__Aspirin
__Anesthetics
__Radiographic Contrast
__Adhesive tape
Shellfish

Medical History: Please indicate any of the following that pertain to you:

__AIDS/HIV
__Anemia
__Arthritis
__Artificial Joints
__Asthma
__Back Pain
__Bleeding Disorder
__Blood Clots
__Cancer
__Coronary Artery Disease
__Deep Vein Thrombosis
__Diabetes
__Dialysis
__Dyslipidemia
__Edema
__Fibromyalgia
__Foot Deformity
__Frost Bite
__Gout
__Headaches/Migraines
__Heart Disease
__Hepatitis
__Hernia
__Hypertension
__Kidney Disease
__Leg or Foot Ulcers
__Liver Disease
__Lung Disease
__Organ Transplant
__Osteoporosis
__Pacemaker
__Peripheral Vascular Disease
__Polio
__Pulmonary Embolism
__Raynaud's Disease
__Rheumatoid Arthritis
__Seizures/Epilepsy
__Stroke
__Substance Abuse
__Thyroid Problems
__Tuberculosis
__Varicose Veins

I certify that the above is true and correct to the best of my knowledge. I give permission to Dr. Tracy Basso to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankle.

Patients Signature (or guardian):_____ **Date:**_____