DR: Naugle / Smith / T. Shannon / M. Shannon / Watson / Zimmerman / Lazar

----------Please Fill Out Below Completely----------

Last Name:_____ First Name:_____

Date of Birth:_____ Gender: [ ] Male [ ] Female Date:_____

Family Doctor:_____ Shoe Size:_____

Date of last family doctor visit:_____

How did you hear about our practice:_____

Please describe what brings you into the office today...

_____

_____

_____

Please circle all that applies in the pain table shown below

Describe Pain	Main Location	For How Long?	Onset of injury/condition	Progression of condition	Pain Aggravated by...
Sharp	Lower Leg	1-3 Days	Gradual onset over time	Severe Worsening	Any Weightbearing
Aching	Ankle	3-7 Days			Standing
Throbbing	Achilles Tendon	1-3 Weeks		Moderate Worsening	Walking
Shooting	Heel	3-6 Weeks			Running
Electrical	Midfoot	6-8 Weeks	Sudden onset from activity	Mild Worsening	Exercise
Pins & Needles	Arch	3-6 Months			Bending
Burning	Toenails	6-9 Months		Steady/Improving	Stooping
Itching	Forefoot	9-12 Months			Pressure on Ball of Foot
	Sole of Foot		Traumatic injury	Mild Improvement	Pressure from Shoe gear
	Ball of Foot				
No Pain	Top of Foot	Greater than One Year		Moderate Improvement	Pressure from jumping
	Big Toe				
	Lesser Toes			Considerable Improvement	

Check all that apply below

	Treatments I have attempted to relieve symptoms		Amount of Improvement I have Achieved
	Anti-Inflammatories (Motrin, Aleve, Tylenol, etc.)		Considerable Improvement to Symptoms
	Changing Shoe gear		
	Rest, Ice, Compression and/or Elevation		Mild Improvement to Symptoms
	Padding and/or Strapping affected foot		
	Trimming Nail(s) yourself		Moderate Improvement to Symptoms
	Applying Ointment and/or cream		No Improvement to Symptoms
	Seen by Another Physician for surgery or treatment		Worsening of Condition

Additional Info:_____

Patient Name:_____

Circle Any Additional Factors: **Pain decreases with removing shoes | Pain decreases with shoe removal | Pain decreases with nail trimming | Pain worse on 1st Step in the Morning | Pain Worse When Walking/Standing after Rest | Pain Worse in Shoes | Pain worse with any movement | Pain worse with exercise | Pain worse on ladder | Pain improves after walking 15-20 min. | Pain decreases with rest**

Past Medical History *(check all that apply)*

	AIDS or HIV Positive		Emphysema		Multiple Sclerosis	Additional Diseases List Below	
	Anemia		Epilepsy		DVT (Blood Clot)		
	Arthritis		Gout		Pacemaker		
	Asthma		Heart Disease		Pneumonia		
	Bleeding Disorder		Hepatitis		Polio		
	Cancer		Kidney Disease		Stroke		
	Chemical Dependency		Liver Disease		Thyroid Disease		
	Diabetes		Migraines		Ulcer(s)		

Past Surgical History *(check all that apply)*

	Toenail Surgery		Heart Bypass	List Surgery with Approximate Month/Year Performed
	Bunion Repair		Heart Valve Surgery	
	Hammertoe Correction		Appendectomy	
	Fracture Repair		Gallbladder	
	Joint Fusion		Brain Surgery	
	Tendon Repair		Stent Placement	
	Ankle Stabilization		Liver Surgery	
	Arthroscopy (Scope)		Tumor Removal	

Complications with surgery or anesthesia:_____

Childhood and Family History *(check all that apply)*

	Childhood Illness		Sibling's Medical History		Father's Medical History		Mother's Medical History
	Rheumatic fever		HTN/High Blood Pressure		HTN/High Blood Pressure		HTN/High Blood Pressure
	Measles		CVA/ Stroke		CVA/ Stroke		CVA/ Stroke
	Mumps		Diabetes		Diabetes		Diabetes
	Rubella		Cancer		Cancer		Cancer
	Chicken Pox		Circulation Problems		Circulation Problems		Circulation Problems
	Herpes/Cold sores		Other:		Other:		Other:
	Clubfoot	Deceased: [ ] Yes, At age___[ ]No		Deceased: [ ] Yes, At age____ [ ]No		Deceased: [ ] Yes, At age____ [ ]No	

Allergies *(check all that apply)*

	No Known Allergies		Sulfa		Aspirin		Adhesive Tape
	Penicillin		Erythromycin		Cortisone		Local Anesthetics

Other Allergies (including Medications/Food/Environmental):

_____

Patient Name:_____

Social History *(circle all that apply)*

Smoke Tobacco / *Drink Alcohol* / *Smoke Marijuana* / *Use Cocaine* / *Use Hallucinogenic Drugs* / *Use Other Drugs*

Smoking Status *(check boxes as they apply)*

	I am a...		Current/Former Smokers: I would typically smoke...				
	Current Everyday Smoker		½ Pack a day		4 Packs a day		Occasionally
	Current Occasional Smoker		1 Pack a day		5 or more Packs a Day		Socially
	Former Smoker		2 Packs a day		1-2 packs per week		Weekdays
	Never Smoker		3 Packs a day		3-4 packs per week		Weekends

Alcohol Use, number of drinks *(circle as they apply)*

Daily Intake: 1 2 3 4 5 5 or More

Weekly Intake: 1-3 Drinks a week 4-6 Drinks a week Occasional Social Only Weekend Only

Non-Drinker (Never Drank or No Longer)

Non-Drinker (In Recovery)

Current Medication List (Note: If you have an existing list, please provide it so we may scan it and write **SEE LIST** on the lines below)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Height:_____

Patient Weight:_____

Date of last Flu shot:_____

[ ] Check this box if you did not get the Flu shot