Allegiance Family Foot Care

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Podiatric History

Name: _____ Date of Birth: _____

Do you wear glasses? _____ Shoe Size: _____ Height: _____ Weight: _____

What type of problem are you experiencing? _____

Where is the location of this problem? (please be specific) _____

How long have you had this problem? _____

How did it occur? Trauma ____ Injury ____ Gradual Onset ____ Rapid Onset ____ Pain off and on ____

How would you describe the pain? Mark all that apply:

Sharp ___ Shooting __ Burning___ Aching___ Throbbing___ Stabbing___ Numbness___

Rate the pain on a scale of 0-10 with 10 being the most severe? (Please circle one)

0 1 2 3 4 5 6 7 8 9 10

What makes the pain feel worse? _____

What makes the pain feel better? _____

Have you see another physician for this condition? Yes___ No___ If yes, who? _____

What treatments have you attempted for this problem? _____

Is there anything else you would like us to know about this problem? _____

Are there any other problems you would like to discuss? _____

Do you experience any of the following problems in your feet or legs? Mark all that apply:

Blood Clots	☐	Burning	☐	Cold Feet	☐	Cramping while at rest	☐
Cramping while walking	☐	Drainage/Weeping	☐	Dry Skin	☐	Excessive Bleeding	☐
Fever/Chills	☐	Itching	☐	Joint Aches	☐	Nail Changes	☐
Nausea/Vomiting	☐	Numbness	☐	Redness	☐	Recent Weight Changes	☐
Stabbing Calf Pain	☐	Swelling and Edema	☐	Tingling	☐	Varicose Veins	☐
Wound or Ulcers	☒						

_____ _____ _____ _____

Patient/Guardian Signature Date Physician Signature Date