Robert Victor, DPM, FACFAS

Patient Name: _____ Today's Date: _____

Reason for being seen: _____ Problem Start Date: _____

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
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Angina (Chest pain)
- ☐ Heart Disease
- ☐ Arrhythmia
- ☐ Heart Murmur
- ☐ Stroke
- ☐ High Cholesterol

Gastrointestinal
- ☐ Acid Reflux
- ☐ GI or Rectal Bleeding
- ☐ Bowel Disorders
- ☐ Hernia
- ☐ Ulcers

Vascular
- ☐ Anemia
- ☐ Leg Pain When Walking
- ☐ Prolonged Bleeding
- ☐ Blood Clots
- ☐ Poor Circulation

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis

Arthritis
- ☐ Artificial Joints
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Rheumatoid
- ☐ Fibromyalgia

HEENT
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hearing Loss

Miscellaneous
- ☐ Bladder Problem
- ☐ Cancer (Type:_____)
- ☐ Hepatitis/Liver Disease
- ☐ Fainting
- ☐ Epilepsy/Seizure
- ☐ HIV
- ☐ Kidney Problem
- ☐ Muscle Disease
- ☐ Prostate Problem
- ☐ Thyroid Disease

Psychological
- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric Care
- ☐ Alcohol Dependence
- ☐ Drug Dependence

Other Medical Problems
- ☐ _____
- ☐ _____
- ☐ _____

Family History
- ☐ Bleeding Disorder Relation:_____
- ☐ Anesthesia Complications Relation:_____
- ☐ Heart Disease Relation:_____
- ☐ Diabetes Relation:_____
- ☐ Cancer Relation:_____

Are you taking medications? (please list below or attach a copy)

_____

What operations have you had? _____

Allergies: If none Please check here ☐ No Known Adverse Drug Reactions

☐ Penicillin Reaction? _____	☐ Sulfa Drugs Reaction? _____	☐ Codeine: Reaction? _____
☐ Latex: Reaction? _____	☐ Adhesive Tape: Reaction? _____	☐ Novocaine/Local Anesthetic: Reaction? _____
☐ General Anesthesia Reaction? _____	☐ 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