REASON FOR VISIT DATE_____

NAME _____ DATE OF BIRTH _____

PLEASE SPECIFY REASON FOR VISIT:

FOOT PAIN: (PLEASE CIRCLE LEFT/ RIGHT/ BILATERAL)

TOES: (L /R /B) HEEL: (L /R /B) ARCH: (L /R /B) BALL OF FOOT:(L /R /B) ANKLE: (L /R /B)

PLEASE CIRCLE ALL THAT APPLY TO TODAY'S VISIT:

DIFFICULTY IN WALKING NUMBNESS TINGLING BURNING ULCERATION

OPEN WOUND CALLUS WART LESION THICK NAILS INGROWN NAIL

RASH DRY SKIN CRACKS ITCHING SWELLING:(LIST AREA) _____

*OTHER:*_____

DO YOU CURRENTLY USE TOBACCO? Y/N HAVE YOU USED TOBACCO IN THE PAST? Y/N

WHEN DID YOU QUIT USING TOBACCO? _____

PLEASE CIRCLE ALL THAT PERTAINS TO YOU:

**DIABETIC *POOR CIRCULATION *KIDNEY FAILURE *ON BLOOD THINNERS*

**BYPASS SURGERY *STENTS ON LEGS *ALLERGIC TO ASPRIN * ALLERGIC TO TAPE*

**ALLERGIC TO IODINE *ALLERGIC TO LATEX*

DRUG ALLERGIES: _____

LOCAL PHARMACY USED:_____ PHARMACY PHONE #_____

PHARMACY LOCATION:_____

I GIVE ASSOCIATES IN FOOT AND ANKLE CARE PERMISSION TO OBTAIN MEDICATION HISTORY IN ORDER TO PROVIDE THE MOST UP TO DATE AND ACCURATE CARE CONCERNING DRUG INTERATIONS AND ALLERGIES... ***YES OR NO (PLEASE CIRCLE)***

**ROUTINE PODIATRY CARE IS NOT COVERED BY YOUR INSURANCE. TRIMMING OF TOENAILS REQUIRES THAT YOU HAVE A QUALIFYING MEDICAL CONDITION THAT HAS BEEN DOCUMENTED BY YOUR PODIATRIST. ANSWER ALL QUESTIONS ABOVE AS COMPLETELY AS POSSIBLE TO ASSURE THAT YOU RECEIVE THE BEST CARE AND THAT ALL MEDICATIONS ARE ACCEPTABLE TO YOUR SITUTATION.

PATIENT SIGNATURE:_____