

Charles J. Sidlow, D.P.M., F.A.C.F.A.S.
 Podiatry
 958 A. Joe Frank Harris Pkwy.
 Suite 106
 Cartersville, GA. 30120

DATE _____

NAME _____ BIRTH DATE _____

PATIENT MEDICAL HISTORY

FAMILY MEDICAL HISTORY

Have you had any of the following?

Has any family member had any of the following?

- | | | |
|---------------------------|-----|----|
| Arthritis | Yes | No |
| Bleeding Disorders | Yes | No |
| Cancer | Yes | No |
| Diabetes | Yes | No |
| Epilepsy/Seizures | Yes | No |
| Glaucoma | Yes | No |
| Heart Disease | Yes | No |
| High Blood Pressure | Yes | No |
| Stroke | Yes | No |
| Thyroid Disease | Yes | No |
| Vascular Disease | Yes | No |
| Diphtheria | Yes | No |
| Measles | Yes | No |
| Mumps | Yes | No |
| Pneumonia | Yes | No |
| Polio | Yes | No |
| Rheumatic Fever | Yes | No |
| Rubella | Yes | No |
| Tetanus | Yes | No |
| Allergies/Hay Fever | Yes | No |
| Anemia | Yes | No |
| Asthma | Yes | No |
| Chronic Rashes | Yes | No |
| Gall Bladder Disease | Yes | No |
| Hepatitis | Yes | No |
| Prostate Disease | Yes | No |
| Scarlet Fever | Yes | No |
| Ulcers | Yes | No |
| Venereal Disease | Yes | No |
| Hiatal Hernia/Acid reflux | Yes | No |
| Fibromyalgia | Yes | No |
| Gout | Yes | No |
| Mitral valve prolapse | Yes | No |
| Neuropathy | Yes | No |
| Tuberculosis | Yes | No |
| Sickle cell disease | Yes | No |
| Skin disorder | Yes | No |
| Bronchitis | Yes | No |
| Currently Pregnant | Yes | No |

- | | | | |
|---------------------|-----|----|-------|
| Arthritis | Yes | No | Who |
| Bleeding Disorders | Yes | No | _____ |
| Cancer | Yes | No | _____ |
| Diabetes | Yes | No | _____ |
| Epilepsy/Seizures | Yes | No | _____ |
| Glaucoma | Yes | No | _____ |
| Heart Disease | Yes | No | _____ |
| High Blood Pressure | Yes | No | _____ |
| Stroke | Yes | No | _____ |
| Thyroid Disease | Yes | No | _____ |
| Vascular Disease | Yes | No | _____ |

HABITS

- | | | |
|---------------------|-----------------|----|
| Do you Smoke? | Yes | No |
| Packs Per Day _____ | How long? _____ | |
| Coffee _____ | Yes | No |
| Cups per Day _____ | | |
| Alcohol _____ | Yes | No |
| How Often? _____ | | |

ALLERGIES

Have you had any allergic reaction to the following?

- | | | |
|---------------------|-----|----|
| Adhesive | Yes | No |
| Aspirin | Yes | No |
| Codeine | Yes | No |
| Iodine | Yes | No |
| Novocaine | Yes | No |
| Penicillin | Yes | No |
| Sulfa | Yes | No |
| Tetanus | Yes | No |
| Latex | Yes | No |
| Other: _____ | | |

Any additional conditions: _____

PLEASE FILL OUT INFORMATION ON THE BACK

NAME _____ BIRTH DATE _____

PERSONAL HISTORY

Height: _____

Shoe Size: _____

Weight: _____

Shoe Width: _____

HOSPITALIZATIONS OR SURGERIES

Please list any surgeries or hospitalizations, please include dates:

MEDICATIONS

Please list all medications that you are currently taking.

HISTORY OF PRESENT ILLNESS

1. Describe your injury or condition: _____
2. Where is the pain/condition located?
____ Left foot/ankle ____ Right foot/ankle ____ Both
3. How would you describe the nature of your pain?
____ Sharp ____ Dull ____ Aching ____ Burning ____ Radiating ____ Itching ____ Stabbing
Other: _____
4. How would rate your pain on a scale from 0 to 10?
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)
5. What part of the foot/ankle is the pain/condition located? _____
6. How long ago did this problem first start? _____
7. Was the onset of the pain sudden or gradual? _____
8. Has the problem stayed the same, worsened, or improved over time? _____
9. What seems to make the pain/condition feel worse? ____ Walking ____ Standing ____ Resting
____ Dress shoes ____ High heels ____ Flat shoes ____ Any closed shoe ____ Daily activities ____ Exercise
Other: _____
10. What makes the condition feel better? _____
11. What treatments have you had for this condition? _____
12. How has this problems affected your lifestyle or ability to work? _____
13. Is this problem the result of an injury? __ Yes __ No, If yes is it work related? __ Yes __ No
14. Have you previously been treated by a foot doctor (Podiatrist) or other foot specialist for foot care? __ Yes __ No