Corpus Christi Podiatry Associates
Patient History

Name____ Age _______ Date: ________________

Height _______Weight ______ Shoe Size________ Occupation _____________________________________

Describe you main foot problem: ____

____

____

Duration - When did your problem start?____________________ Was it? (Circle) Gradual Progressive Rapid

Primary Care Physician: ______________________________ Last Visit and why? _________________

General Health:

Do you have Diabetes? Yes ___ No ___ When were you first diagnosed? ____________________________

Most recent blood sugar and/or HbA1c _______________ Do you take Insulin ____ Pills _____ Both ____ ?

When was your last eye exam___________ Are you on Dialysis ________ when______________________ ?

Females: Is there any chance of pregnancy? Yes ____ No ____ Uncertain_____________________________

Medications: ____

____

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Allergies:(Circle) NKDA Penicillin Sulfa Codeine Aspirin Novocain Iodine Adhesive Tape Other ______

Social History: Do you smoke? ____ Amount _____ Do you drink alcohol _____ Amount________________

Did you smoke? ___ When did you quit smoking?_________ Quit Alcohol? ______________

Family History:

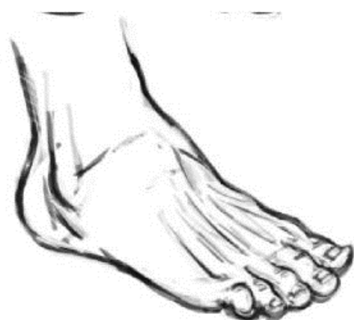
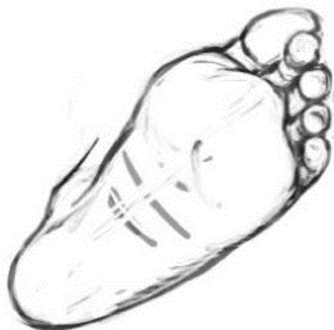
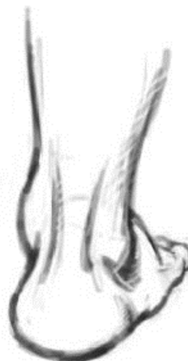
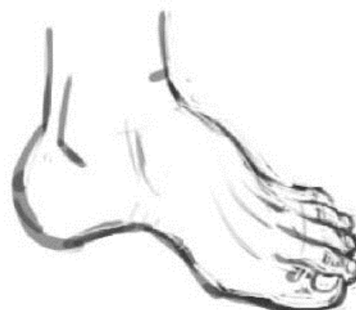
You / Family	**You / Family**	**You / Family**
___/___ Heart Problems	___/___ Epilepsy or Seizures	___/___ Rheumatic Fever
___/___ Kidney Problems	___/___ High Blood Pressure	___/___ Scarlet Fever
___/___ Lung Problems	___/___ Asthma	___/___ Hepatitis
___/___ Liver Problems	___/___ Arthritis	___/___ AIDS/ HIV
___/___ Circulation Problems	___/___ Cancer	___/___ Varicose Veins
___/___ Bleeding Problems	___/___ Diabetes	___/___ Stomach Problems

Past Hospitalizations: ____

Past Surgeries: ____

Other Medical Problems: ____

Please mark the area where your foot hurts. Right_____ Left _____ Both _____

Completed By: ___________________________________ Reviewed By: ______________________________