New Patient Podiatric History Form

Dr. Lisa K. Rechkemmer
Dr. Frank H. Russo

Instep Podiatry, PC
200 E. Willow Ave.
Wheaton, IL 60187
630.462.1470

Please Print

Patient Name_____Date_____

Age_____ Height_____Weight_____Shoe Size_____

Primary Care Physician_____

Pharmacy Name and Address_____

Chief Complaint *(Nature of your foot pain or problem)*_____

_____

Location on foot or leg:
Check all that apply

__ Forefoot/Toes __Middle Foot __ Back Part of Foot
__Ankle __Top __ Bottom
__Outer Side __Inner Side

How long has this bothered you? _____
How did this begin? _____
What course has it taken? _____
What aggravates it? _____
What makes it feel better?_____
What have you done to relive the condition? _____
_____
(If you have seen another doctor to relieve the pain, please give his/her name)
_____

Please list the prescriptions that you take:_____
_____
_____
_____
_____
_____

Are you using any over the counter medications?_____
If so, which ones *(names)*?_____
_____
_____

Please turn this paper over and complete the questions on the back

08.03.11

General Health: *If you have had or have any of the following, check all that apply:*

__Hip problems	__ Pneumonia	__ Pain, cramps, swelling, tingling
__ Ankle problems	__ Headaches	__ Burning or numbness in feet
__ Shingles	__ Bruise easily	__ Burning or numbness in legs
__ Skin problems	__Neck pain	__ HIV
__ Bone fracture	__ Lower back pain	__ Shortness of breath

Can you take aspirin?_____
Have you had a local anesthetic *(such as dental work)*?_____
Did you have any problems with it?_____
Do you smoke?_____How much?_____For how long?_____
Do you drink?_____How much?_____For how long?_____

Past surgeries or hospitalizations: _____
_____
_____

Allergies
Are you allergic or sensitive to:

__ Penicillin	__Novocain	__ Anesthetics	__Codeine
__ Adhesive Tape	__Iodine	__Metal	__Sulfa

__Drugs:_____
__ I am not allergic to anything that I know of.

Family Health
Have you or any of your family members ever had any of the following *(please check all that apply)*

You	Family		You	Family	
___	___	Diabetes	___	___	Epilepsy
___	___	Heart trouble	___	___	Nerve disease
___	___	High blood pressure	___	___	Muscle disease
___	___	Bleeding problems	___	___	Bone disease
___	___	Kidney trouble	___	___	Varicose veins
___	___	Liver problems	___	___	Arthritis
___	___	Anemia	___	___	Cancer
___	___	Lung disease	___	___	Asthma
___	___	Blood disease	___	___	Gout

I certify that the above information is accurate and true to the best of my knowledge.

Signature:_____**Date:**_____