STEVEN L. GINEX, D.P.M.
PALM DESERT PODIATRY CENTER

PATIENT: _____

FOOT HISTORY:

WHAT IS THE REASON FOR YOUR VISIT TODAY: _____

_____

_____

(a) HOW LONG HAVE YOU HAD THIS FOOT CONDITION? _____ O DAYS O WEEKS O MONTHS O YEARS

(b) HOW LONG HAS CONDITION BEEN ACUTE OR PAINFUL? _____ O DAYS O WEEKS O MONTHS O YEARS

(c) WAS THE ONSET GRADUAL OR SUDDEN? _____

On a scale of 1 - 10 (1 being no pain and 10 being the worst) what is your level of pain? _____

THE PAIN QUALITY IS: O BURNING O CONSTANT O DULL O SHARP O SHOOTING

O THROBBING O TINGLING Other_____

ANY PREVIOUS FOOT TREATMENT?_____ IF SO, WHEN WAS THE LAST TIME?_____

FOR WHAT? _____

BY WHOM? _____

HOW FREQUENTLY TREATED? _____

RESULTS OF PREVIOUS CARE? _____

Height: _____ft._____in Weight: _____Lbs. Shoe Size: _____ N M W

MEDICAL HISTORY:

HAVE YOU EVER BEEN TREATED FOR OR DO YOU HAVE ANY OF THE FOLLOWING?

HEART DISEASE	YES / NO	VARICOSE VEINS	YES / NO
CIRCULATORY PROBLEMS	YES / NO	TUMORS (malignant or benign)	YES / NO
ASTHMA	YES / NO	RHEUMATIC FEVER	YES / NO
PNEUMONIA	YES / NO	POLIO	YES / NO
TUBERCULOSIS	YES / NO	YELLOW JAUNDICE	YES / NO
OTHER LUNG CONDITION	YES / NO	HEPATITIS	YES / NO
LOW BACK PAIN	YES / NO	BLOOD TRANSFUSION	YES / NO
LEG PAIN	YES / NO	ARTHRITIS	YES / NO
MUSCLE CRAMPS	YES / NO	BURSITIS	YES / NO
HIGH BLOOD PRESSURE	YES / NO	EPILEPSY	YES / NO
LOW BLOOD PRESSURE	YES / NO	KIDNEY PROBLEMS	YES / NO
COLITIS	YES / NO	STOMACH ULCERS	YES / NO
GOUT	YES / NO		

CHILDHOOD DISEASES:

MEASLES? YES / NO
CHICKEN POX? YES / NO
MUMPS? YES / NO

FOR WOMEN ONLY:

ABORTIONS? YES / NO #_____
MISCARRIAGES? YES / NO #_____
FULL TERM: YES / NO
HYSTERECTOMY? YES / NO

PATIENT: _____

ARE YOU DIABETIC? YES / NO TYPE OF DIABETES: TYPE 1 OR TYPE 2

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IF SO, HOW IS YOUR DIABETES CONTROLLED (drugs or diet)? _____

DOCTOR'S NAME AND ADDRESS:_____ LAST VISIT: _____

_____

_____

WHAT MEDICATIONS DO YOU TAKE REGULARLY? PLEASE LIST _____

_____

_____

ARE YOU ALLERGIC OR SENSITIVE TO: PAIN MEDICATION? _____ ANTIBIOTICS? _____

ADHESIVE TAPE? _____ IODINE_____ SHELL _____ LOCAL OR GENERAL ANESTHETICS? _____

IF YES, SPECIFY TYPE OF DRUG AND TYPE OF REACTION: _____

_____

PHARMACY NAME AND ADDRESS: _____

_____

PHARMACY TELEPHONE NO._____ PHARMACY FAX NO. _____

PREVIOUS SURGERIES: (TYPE, DATES, COMPLICATIONS, if any:) _____

_____

PAST SERIOUS INJURIES: (TYPE, DATES, COMPLICATIONS, if any:) _____

_____

PERSONAL HABITS:

DO YOU CURRENTLY SMOKE? YES / NO HOW MANY PACKS/DAY? _____ HOW MANY YEARS? _____

DID YOU SMOKE PREVIOUSLY? YES / NO HOW MANY PACKS/DAY?_____ HOW MANY YEARS?_____ YEAR QUIT:_____

DO YOU DRINK ALCOHOL? O YES, EVERYDAY (5-7 day/week) O YES, OCCASIONALY/SOCIALLY O RARELY O NO

SUBSTANCE ABUSE:

_____ YES, I HAVE A CURRENT SUBSTANCE ABUSE PROBLEM. IF SO, PLEASE SPECIFY: _____

_____

_____ YES, I HAD A PAST SUBSTANCE ABUSE PROBLEM. PLEASE SPECIFY: _____

_____

_____ NO, I DO NOT HAVE A SUBSTANCE ABUSE PROBLEM.

WHAT IS YOUR OCCUPATION? _____ DOES IT INVOLVE MOSTLY O STANDING O SITTING

DO YOU EXERCISE REGULARLY? O YES, I DO THE FOLLOWING REGULAR EXERCISE: _____

O NO, I DO NOT EXERCISE REGULARLY