



NAME: _____ DOB: _____ SHOE SIZE _____

PRIMARY COMPLAINT: _____

RIGHT FOOT (PLEASE CIRCLE IF IT APPLIES)

WHOLE FOOT	BALL OF FOOT	TOP OF FOOT	ARCH	HEEL
GREAT TOE	SECOND TOE	THIRD TOE	FOURTH TOE	LESSER TOE
ANKLE	LEG	NAIL FUNGUS	INGROWN	

LEFT FOOT (PLEASE CIRCLE IF IT APPLIES)

WHOLE FOOT	BALL OF FOOT	TOP OF FOOT	ARCH	HEEL
GREAT TOE	SECOND TOE	THIRD TOE	FOURTH TOE	LESSER TOE
ANKLE	LEG	NAIL FUNGUS	INGROWN	

NATURE OF THE PAIN

SHARP DULL ACHING BURNING RADIATING STABBING ITCHING OTHER _____

Pain Scale: 1-10 (1=LOW/10=HIGH) 1 2 3 4 5 6 7 8 9 10

IS YOUR PROBLEM: OCCASIONAL FREQUENT INTERMITTENT CONSTANT

SWELLING? NONE MILD MODERATE SEVERE

HAVE YOU EVER BEEN TREATED FOR THIS PROBLEM? WHEN? TREATMENT? DR'S NAME

WHAT HOME TREATMENTS HAVE YOU ATTEMPTED, IF ANY?

ORAL/TOPICAL MEDICATIONS ICE NEW SHOES INSERTS REDUCED ACTIVITY

WHEN DID THE PROBLEM START? DAYS _____ WEEKS _____ MONTHS _____ YEARS _____

IS THE PROBLEM INJURY RELATED? IF YES PLEASE, EXPLAIN IN
DETAIL _____

WHAT MAKES THE PROBLEM WORSE?

STANDING WALKING RUNNING EXERCISE SHOES DAILY ACTIVITIES

WHAT MAKES THE PROBLEM BETTER?

NAME _____

DOB _____

DO YOU EXERCISE REGULARLY? NO YES/HOW OFTEN _____

DO YOU DRINK ALCOHOL? YES, HOW MANY PER DAY? NO YES _____

DO YOU USE RECREATIONAL DRUGS? YES, IF SO PLEASE LIST: NO YES _____

TOBACCO USE?

NEVER FORMER, NUMBER OF YEARS _____ CURRENT _____ PACKS PER DAY/YEARS _____

OTHER TOBACCO: PIPE E-CIGARETTE SNUFF CHEW

DO YOU HAVE ANY OF THE FOLLOWING?

- | | | | |
|----------------|----------------|--------------------|--------------------|
| ITCHING | LEG CRAMPING | MUSCLE/JOINT PAIN | DIZZINESS/FAINTING |
| RASH | LEG WEAKNESS | STIFFNESS | TREMORS |
| DEFORMED NAILS | CLOTS IN LEGS | BACK PAIN | SEIZURES |
| PSORIASIS | COLD FEET | REDNESS OF JOINTS | WEAKNESS |
| SKIN CANCER | VARICOSE VEINS | SWELLING OF JOINTS | NUMBNESS |
| ECZEMA | | TRAUMA | TINGLING |

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? IF YES, PLEASE LIST...

NEW PATIENTS ONLY: MEDICATION LIST



OFMC Podiatry Clinic
2131 SW 20th Place
Ocala, FL 34471
(352) 368-1370

Dear Patient:

Welcome to Ocala Family Medical Center. Our goal is to improve your quality of life.

It is our policy to charge for missed appointments at the rate of:

New Patient Appointment: \$100.00 dollars

Follow Up Appointment: \$75.00 dollars

Missed Procedures: \$100.00 dollars

Please help us to serve you better by keeping your scheduled appointments. If you are unable to keep this appointment, please call (352) 368-1370 to reschedule your appointment at least 24-hours in advance.

Sincerely,
The Staff of Ocala Family Medical Center

I have read and understand the above no show policy for OFMC Podiatry clinic.

Print Name

Witness

Signature

Date

Effective: 02/01/2024