Name: ______________________________ DOB: ______________

Primary Complaint: ____

Height: __________ Weight: __________ Shoe Size: __________

Location:

RIGHT

- ☐ Whole Foot ☐ Ball of Foot ☐ Top of Foot ☐ Arch ☐ Heel
- ☐ Great Toe ☐ Second Toe ☐ Third Toe ☐ Fourth Toe ☐ Lesser Toe
- ☐ Ankle ☐ Leg

LEFT

- ☐ Whole Foot ☐ Ball of Foot ☐ Top of Foot ☐ Arch ☐ Heel
- ☐ Great Toe ☐ Second Toe ☐ Third Toe ☐ Fourth Toe ☐ Lesser Toe
- ☐ Ankle ☐ Leg

Nature of the Pain: (Please answer all that apply)

- ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
- ☐ Radiating ☐ Stabbing ☐ Itching ☐ Other __________

Pain Scale:

	1	2	3	4	5	6	7	8	9	10	
LOW	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	HIGH

Is your Problem: ☐ Occasional ☐ Frequent ☐ Intermittent ☐ Constant

Swelling:

☐ None ☐ Mild ☐ Moderate ☐ Severe

Have you ever had previous medical treatment for this problem? ☐ Yes ☐ No

If yes, what treatments? Please list doctor's name.

____

What home treatments have you attempted if any?

- ☐ Oral or Topical Medication ☐ Ice ☐ New Shoes ☐ Inserts ☐ Reduced Activity
- ☐ Other __________

Do you have any other complaints or problems? ☐ Yes ☐ No

If yes, please list:

____

When did the problem start? ☐ Suddenly ☐ Gradually

Duration: Days: ______ Weeks: ______ Months: ______ Years: ______

Is this problem related to an injury? ☐ Yes ☐ No

If yes, please provide the date and details of the injury:

____

What makes your problem worse?

- ☐ Standing ☐ Walking ☐ Running ☐ Exercise
- ☐ Work ☐ Shoes ☐ Daily Activities

What makes your problem better?

____

Name: ______________________________ DOB: ______________

Medical History

Please indicate with a (✓) any of the medical conditions below that pertain to you

- ☐ Arthritis
- ☐ Back Pain
- ☐ Bleeding Disorders
- ☐ Circulatory Problems
- ☐ Deep Venous Thrombosis (DVT)
- ☐ Diabetes, Type II
- ☐ Edema
- ☐ Fracture
- ☐ Gout
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Pulmonary Embolus
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Other: ____________

Surgical History

Please indicate with a (✓) any of the surgical conditions below that pertain to you, and circle which anatomical side.

- ☐ Amputation of Foot Right/Left
- ☐ Amputation of Toes Right /Left
- ☐ Ankle Surgery Right /Left
- ☐ Bunion Surgery Right /Left
- ☐ Colon Surgery
- ☐ Foot Surgery Right /Left
- ☐ Fracture Repair, Ankle Right/Left
- ☐ Fracture Repair, Foot Right/Left
- ☐ Hammertoe Surgery Right /Left
- ☐ Hip Replacement Right /Left
- ☐ Knee Replacement Right /Left
- ☐ Open Heart Surgery
- ☐ Organ Transplant
- ☐ Pacemaker/Defibrillator
- ☐ Vein Surgery/Artery Surgery
- ☐ Other ______________

Family History

Please indicate with a (˙) for family members who have had any of the following conditions

Relationship	Diabetes	Arthritis
Father		
Mother		
Brother(s)		
Sister(s)		
Son(s)		
Daughter(s)		

Name: ______________________________ DOB: ________________

Social History

Please indicate with a (✓) any of the responses that pertain to you

Marital/Living Status:

· Single · Married · Separated · Divorced · Widowed

Employment:

· Working Full Time · Working Part Time · Retired · Self Employed · Unemployed

Exercise:

Do you exercise regularly? · No · Yes

Substances:

Alcohol:

Do you drink alcohol? · No · Yes: ______ Drinks Per Day

Drug Use:

Do you use any recreational drugs? · No · Yes

Tobacco Use

Cigarettes:

· Never

· Former Smoker: ______ Number of Years Quit Date ______________

· Current Smoker: ______ Packs per day ______ Number of Years

Other Tobacco: · Pipe · Cigar · Snuff · Chew

Are you interested in quitting? · Not ready to quit · Thinking about quitting · Ready to quit

Review of Systems

Please indicate with a (✓) any of the medical conditions below that pertain to you, if none of the below apply, (✓) Not Applicable

Integumentary:	Vascular:	Musculoskeletal:	Neurology:
☐ Itching	☐ Leg cramping	☐ Muscle or joint pain	☐ Dizziness
☐ Rash	☐ Leg weakness	☐ Stiffness	☐ Fainting
☐ Deformed nails	☐ Clots in legs	☐ Back pain	☐ Seizures
☐ Psoriasis	☐ Feet cold	☐ Redness of joints	☐ Weakness
☐ Skin cancer	☐ Varicose veins	☐ Swelling of joints	☐ Numbness
☐ Eczema	☐ Not Applicable	☐ Trauma	☐ Tingling
☐ Not Applicable		☐ Not Applicable	☐ Tremors
			☐ Not Applicable

Allergies

Please indicate with a (✓) if you have any allergies to medications? · No · Yes, if yes, list below

____

____

NEW PATIENTS ONLY: Medication List

____

____

____

____

____

____

____

Ocala Family Medical Center Inc.
2131 SW 20th Place
Ocala, Fl 34471-1391

Dear Patient:

Welcome to OFMC Podiatry Center. Our goal is to improve your quality of life.

It is our policy to charge for missed appointments at the rate of $50.00 dollars and missed procedures at the rate of $100. Please help us to serve you better by keeping your scheduled appointments. If you are unable to keep this appointment please call (352) 237-4133 to reschedule your appointment at least 24 hours in advance.

Sincerely,

The Staff of OFMC Podiatry Center

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

____

Print Name