Dear Patient,

As of January 1, 2012 this office starting using EHR (Electronic Health Records). The EHR system is a computerized medical record created in an organization that will help improve patient care, and improve efficiency in hospital and physicians offices.

We know that your time is valuable and we want to provide you with the best care possible. Below are the questions that are required for us to ask each patient. As you can see, this process can be time consuming. We ask that you kindly take a few minutes and answer the questions ahead of time to the best of your knowledge.

When one of our Dr. Assistants call you back to the exam room, they will need only a few minutes to review your history, take vitals, examine and prep you for your appointment.

Thank you in advance for your help with completing your medical record for our office.

Patient Name_____ DOB: _____ Date:_____

Medical History supplied by: Patient___ Mother___ Father___ Sibling___ Grandparent___ Caregiver___ Child___

Diagnosis	No	Yes	If yes, please give a brief explanation:
Diabetes			Doctor currently treating/caring for your diabetic condition: _____ Approximate last appointment date with your doctor who treats/cares for your diabetic condition:_____ Length of time that you have been a diabetic:_____ Type of Diabetes: Insulin Dependant___ Oral Medication:___ Diet Controlled: ___ Previous foot ulceration: yes___ no___ Daily checking of blood sugar level: yes___ no___ Most recent blood sugar reading level: _____ Kidney or Urinary problems: yes___ no___ Diabetic Neuropathy: yes___ no___ Burning/unusual sensations to feet: yes___ no___ Diabetes currently under control: yes___ no___ If so, how long: _____
MRSA			
Abnormal Bruising, Bleeding, Scarring			
Abnormal heart rhythm			
Anemia			
Ankle injury			
Anorexia/Bulimia			
Anxiety			
Arch pain			
Are your first steps out of bed/after rest painful?			
Asthma			
Arthritis			
Athlete's Foot			
Bleeding disorders			
Blood Clots, Deep Vein Thrombosis or other Vascular Disease			
Broken foot bone			
Bunions			
Cancer			
Childhood foot problems			
Corns/ Calluses			

PLEASE CONTINUE ON THE BACK OF THIS SHEET

Diagnosis	No	Yes	If yes, please give a brief explanation:
Cramps in legs/feet			
What percent of hours are you on your feet per day?			
Decrease hearing			
Depression			
Do you wear a brace? What style?			
Do you have joint implants?			
Do you have replacement heart valves?			
Do you have vascular grafts?			
Emphysema			
Fibromyalgia			
Flat feet			
Foot injury			
Foot numbness			
Fungal nails			
Gait (walking problems)			
Gout			
Hammer toes			
Have you ever worn shoe inserts/orthotics?			
>> Do they help?			
>> Still wearing them?			
Heart attack			
Heart failure/CHF			
Heel pain			
Hepatitis			
High blood pressure			
High arch feet			
HIV or other immunosuppressive condition			
Ingrown toenail			
Intoeing			
Kidney failure			
Knee pain			
Leg or foot ulcer/s			
Leg pain when walking			
Liver Disease			
Lower back pain			
Lung Disease/COPD			
Muscle weakness			
Multiple Scoliosis			
Neuroma			
Osteoarthritis			
Osteoporosis			
Rash on feet or ankles			
Rheumatoid Arthritis			
Seizures			
Slow healing after cuts			
Stents			
Stomach Ulcers, GERD, or Bad Heartburn			
Stroke			
Thyroid Disease			
Toe walking			
Warts			
OTHER:			

Do you use any type of assistive device: No___ Yes___ If yes, what type:_____

Maximum Walking Distance: Unlimited___ Limited___ If limited, how many blocks:_____

Difficulty with the following: Climbing stairs___ Inclines___ Ladders___ Standing___ Uneven ground___

Exercise: Not regularly___ Once per week___ 2-3 times per week___ Daily___

Active in any sports/dance? No___ Yes___ If yes, what type?_____

Alcohol Status: None___ Rare___ Socially/Occasional___ Current alcohol___ Former drinker___ Recovering alcoholic___

Do you use recreational drugs? No___ Yes___

Smoking status: Not a smoker___ Social smoker___ Current smoker___ ,packs per day_____

Former smoker___,How long ago did you quit_____ How long smoked_____

Martial Status: Married___ Single___ Divorced___ Widowed___

Number of children:_____

Who do you live with? Alone___ Spouse___ Children: Son___, Daughter___ Significant other___ Father___ Mother___ Parents___ Grandparent(s)___ Guardian___ Other_____

Do you have any pets? No___ Yes___ How many?___ What kind?_____

Occupation/Work status: Full-time___ Part-time___ Retired___ Student___ Homemaker___ Unemployed___ Other_____

Nutrition: Poor diet___ Average diet___ Good diet___ Excellent diet___ Vegetarian___

Have you been hospitalized or under inpatient medical/surgical care for more than 24 hours? No___ Yes___
Please provide a list of surgeries or list below:

_____

_____

Are you currently pregnant? No___ Yes___

Please provide us with a list of your current medications and/or allergies.

Have any of your family members ever had the following?

Diagnosis	Mother	Father	Sister	Brother	Daughter	Son	Grandmother -maternal	Grandfather -maternal	Grandmother –paternal	Grandfather –paternal	Aunt	Uncle	Niece	Nephew	Other
Foot Problems (bunions, hammertoes, Plantar Fasciitis)															
Asthma/COPD															
Bleeding Disorders															
Cancer															
Diabetes															
High Blood Pressure															
Mental illness															
Osteoarthritis															
Rheumatoid Arthritis															
Stroke															
Systemic Lupus															
Thyroid Disease															
OTHER:															