



Podiatric History and Physical Examination

Name _____ Today's Date _____
 Age _____ Date of Birth _____ Male Female

To be completed by the patient

Reason for visit *(Describe foot problems and concerns)*

MEDICAL HISTORY *(check if you had or have any of the following)*

Diabetes	Type I	Type II	Controlled	Uncontrolled
Hypertension <i>(High Blood Pressure)</i>		Tuberculosis	Asthma	Kidney Disease
Bleeding/Clotting Disorders		Rheumatic Fever	Anemia	Gout
PVD <i>(Circulation Disease)</i>		Arthritis	Cancer	Epilepsy
Hepatitis <i>(Liver Disease)</i>		Stomach Ulcers	Cramps or numbness in feet or legs	

Other(s) _____

MEDICATIONS *(Including Non-Prescription Medications)*

ALLERGIES

<i>NKDA (no known drug allergies)</i>	Penicillin	Sulfa	Egg	Latex
Local Anesthetic	Aspirin	Codeine	Tape	Iodine
IV dye	Other(s):			

PAST SURGICAL HISTORY *(Please include date of surgery)*

SOCIAL HISTORY Smoking (packs/day x yrs) _____ Alcohol _____ Recreational Drugs
 Other _____

FAMILY HISTORY Diabetes Heart Disease Cancer Hypertension Anemia Stroke

I hereby give permission to Hudson Valley Foot Associates to examine and/or administer treatment as necessary in the diagnosis and/or treatment of my foot problem(s). I further authorize the release of pertinent medical information to my insurance carrier(s). I hereby authorize payment directly to the physician providing services for which benefits are payable.

Signed _____ Date _____
If signed as parent/guardian, state relationship to patient _____