Dr. David Carmack PLLC

NAME_____ **DATE OF BIRTH**_____ **DATE**_____

PODIATRIC HISTORY

CHIEF COMPLAINT (reason for your visit here today)_____

_____

_____

_____

DESCRIBE TYPE OF PAIN:

☐ Dull ☐ Aching ☐ Sharp
☐ Shooting ☐ Throbbing ☐ Burning
☐ Tingling ☐ Cramping ☐ Numbness
☐ Other_____

LOCATION: ☐ Right ☐ Left ☐ Both
☐ Foot ☐ Ankle ☐ Leg ☐ Knee

DURATION (How long have your symptoms been present): _____ Days Weeks Months Years

ONSET: ☐ Slow ☐ Sudden ☐Traumatic

IF TRAUMATIC: ☐ Auto ☐ Worker's Comp ☐ Other

HAS PAIN BECOME: ☐ Better ☐ Worse ☐ Stayed the same

SYMPTOMS ARE WORSE: ☐ Morning ☐ Evening ☐ Night ☐ All Day

WHAT AGGRAVATES THE CONDITION?

_____

_____

LIST PREVIOUS TREATMENTS: _____

_____

_____

WHO REFERRED YOU TO OUR OFFICE?_____

WHO IS YOUR PRIMARY PHYSICIAN?_____

May we contact your physician regarding your care? Y N

Date you last saw your primary doctor _____

PREVIOUS PODIATRIST? Y N

WHO?_____

WHEN?_____

MEDICAL HISTORY

Please check to indicate if you have had any of the following:

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
  Type_____
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Disorder
- ❑ Bipolar Disorder
- ❑ Blood Clot/DVT
- ❑ Bypass Surgery
- ❑ Cancer
  Type_____
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Depression
- ❑ Diabetes
  Type_____ How Long____
- ❑ Emphysema
- ❑ Eye Problems
- ❑ Fibromyalgia
- ❑ Gastric Reflux
- ❑ Gout
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Failure
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Intestinal Disorder
  Type_____
- ❑ Kidney Problems
  Type_____
- ❑ Liver Disease
  Type_____
- ❑ Low Blood Pressure
- ❑ Neuropathy
- ❑ Pacemaker
- ❑ Paralysis
- ❑ Psoriasis
- ❑ Rheumatic Fever
- ❑ Schizophrenia
- ❑ Seizures/Epilepsy
- ❑ Stroke
- ❑ Thyroid Problems
  Type_____
- ❑ Tuberculosis
- ❑ Ulcers (stomach)
- ❑ Varicose veins

❑ **Other**_____

WOMEN, are you...Pregnant? Y N Breastfeeding? Y N

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MEDICATIONS

Please include prescriptions, over-the-counter medications, and vitamins. (Or provide a list to be photocopied):

Name:_____ Dosage:_____ Frequency:_____
Name:_____ Dosage:_____ Frequency:_____
Name:_____ Dosage:_____ Frequency:_____
Name:_____ Dosage:_____ Frequency:_____
Name:_____ Dosage:_____ Frequency:_____
Name:_____ Dosage:_____ Frequency:_____
Name:_____ Dosage:_____ Frequency:_____
Name:_____ Dosage:_____ Frequency:_____
Name:_____ Dosage:_____ Frequency:_____
Name:_____ Dosage:_____ Frequency:_____
Name:_____ Dosage:_____ Frequency:_____

ALLERGIES

Any allergies or adverse reactions to the following? (please list type of reaction)

Local anesthesia _____ Y N
Aspirin _____ Y N
Anti-inflammatory _____ Y N
Penicillin _____ Y N
Sulfa _____ Y N
IVP dye _____ Y N
Tetanus _____ Y N
General anesthesia _____ Y N
Latex _____ Y N
Tape/Adhesives _____ Y N
Iodine _____ Y N
Betadine _____ Y N
Codeine _____ Y N
Steroids_ _____ Y N

Other antibiotics (name)_____
Other medications (name) _____
_____
Preferred Pharmacy:_____ Pharmacy phone #:_____

SURGICAL AND HOSPITALIZATION HISTORY

Please list previous surgeries and hospitalizations with approximate dates (year):

_____
_____
_____
_____
_____

SOCIAL HISTORY

Your Occupation: _____
Do you smoke? Y N How many packs/day? _____
Did you smoke previously? Y N Packs/day? _____ How many years? ____
Do you drink alcohol? Y N If so, how much? _____ How often? _____

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NAME_____ **DATE OF BIRTH**_____ **DATE**_____

FAMILY HISTORY

Family history (mother, father, grandparents, or siblings) of: Please list WHO in the space provided?

- ☐ Heart Disease _____
- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ Stroke _____
- ☐ Varicose Veins _____
- ☐ Gout _____
- ☐ Arthritis _____
- ☐ Neuropathy _____
- ☐ Bleeding Disorder _____
- ☐ Foot Problems _____

Father: Living_____ Age_____
Deceased_____ Age_____ Cause_____

Mother: Living_____ Age_____
Deceased_____ Age_____ Cause_____

Brother(s): Living_____ Age(s)_____
Deceased_____ Age(s)_____ Cause_____

Sister(s): Living_____ Age(s)_____
Deceased_____ Age(s)_____ Cause_____

REVIEW OF SYSTEMS (Circle any problems you are CURRENTLY having)

CONSTITUTIONAL ..... fever, chills, weight loss, fatigue

SKIN..... rash, excessive sweating, color change, itching, sores, nail problems callus/corn

HEENT ..... sinus problems, allergies, visual or hearing problems, nosebleeds, sleep apnea

ENDOCRINE ..... excessive thirst, heat or cold intolerance, weight loss or gain, hormonal changes

CHEST/RESPIRATORY ..... shortness of breath, wheezing, cough

CARDIOVASCULAR ..... chest pain/angina, irregular heartbeat, swelling of legs/feet, heart trouble

ABDOMINAL..... peptic ulcer, irritable bowel syndrome, stomach pain, gallbladder problems, heartburn, diarrhea, constipation

MUSCULOSKELETAL ..... joint pain, stiffness, neck or low back pain, muscle pain, shoulder or knee problems, hip, carpal tunnel

NEUROLOGICAL..... fainting spells, blackouts, burning pain, sciatica, numbness, weakness, gait problems, dizziness, tremors, cramping in foot and/or leg, memory problems, seizures

AGE:_____ **HEIGHT:**_____ **WEIGHT:**_____ **SHOE SIZE:**_____