family foot docs

New Patient Questionnaire

To better treat you, please complete the following questionnaire:

For what reason are you being seen today?

_____
_____
_____
_____

When did this begin?

_____

Have you attempted or sought any treatment before today?
(This may include home/self treatment, ie: stretching, icing or OTC medication.)
Yes ____ No ____
If yes, please explain.

_____
_____
_____

Have you reached any level of improvement with the above mentioned treatment?
Yes ____ No ____ N/A ____
If yes, please explain.

_____
_____
_____

Is the type of pain you are experiencing: (check all that apply)

____burning
____aching
____dull
____sharp
____shooting
____constant
____worse after activity
____worse in the morning

Rate your pain on a scale of 1-10, 10 being the worst.

1 2 3 4 5 6 7 8 9 10

Signature_____ **Date**_____

Initial Review of Systems

Please check if you have/had problems related to the areas indicated

_____
Date

1. Constitutional	Yes	No
Fatigue	☐	☐
Fevers	☐	☐
Sweats	☐	☐
Weight Change	☐	☐
2. Eyes		
Cataracts	☐	☐
Glaucoma	☐	☐
Vision Surgery	☐	☐
3. Ear, Nose, Throat		
Dizziness	☐	☐
Gum Bleeding	☐	☐
Loss of hearing	☐	☐
Nose bleeding	☐	☐
4. Skin		
Cancers	☐	☐
Rash	☐	☐
5. Musculoskeletal		
Gout	☐	☐
Osteoarthritis	☐	☐
Rheumatoid arthritis	☐	☐
6. Neurologic		
Head Injury	☐	☐
Nerve damage	☐	☐
Seizures	☐	☐
Stroke	☐	☐
7. Urinary System		
Kidney Stones	☐	☐
Incontinence	☐	☐
Prostate problems	☐	☐
Trouble urinating	☐	☐
Urinary Tract/Bladder Infections	☐	☐

8. Endocrine System	Yes	No
Anabolic Steroids	☐	☐
Diabetes	☐	☐
Hormone Treatment	☐	☐
Thyroid Problem	☐	☐
9. Respiratory		
Asthma	☐	☐
Bronchitis	☐	☐
Chronic cough	☐	☐
Pneumonia	☐	☐
Shortness of breath	☐	☐
10. Gastrointestinal		
Blood in stools	☐	☐
Diarrhea/constipation	☐	☐
Gallbladder disease	☐	☐
Hepatitis _____	☐	☐
Hernia/repair	☐	☐
Reflux	☐	☐
11. Cardiovascular		
Anemia	☐	☐
Chest pain/Angina	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Phlebitis/blood clot	☐	☐
Rheumatic fever	☐	☐
Transfusions	☐	☐
12. Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
13. Breast/Genital		
Genital Infections	☐	☐
Masses	☐	☐
Menopause	☐	☐

Other: _____

_____

The information provided on this form is true and correct to the best of my knowledge.

Patient Signature _____ Date_____

Form reviewed by physician: _____Date_____