

# MEDICAL RECORD

## ❖ 1 - General Patient Information

PATIENTS FULL NAME (Last, First, M)	DATE	BIRTHDATE	HEIGHT	WEIGHT
ADDRESS			SHOE SIZE	

## ❖ 2 - Patient's Medical History

MEDICAL CONDITIONS	ALLERGIES																																																																																																																																																														
<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Alzheimer's</td> <td><input type="checkbox"/> Headaches / Migraines</td> <td><input type="checkbox"/> Poor Circulation (PVD)</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> Psoriasis/Eczema</td> </tr> <tr> <td><input type="checkbox"/> Angina (Chest Pain)</td> <td><input type="checkbox"/> Hepatitis (A, B, C, D, E)</td> <td><input type="checkbox"/> Psychiatric Disorder</td> </tr> <tr> <td><input type="checkbox"/> Anxiety</td> <td><input type="checkbox"/> Hiatal Hernia</td> <td><input type="checkbox"/> Raynauds Disease</td> </tr> <tr> <td><input type="checkbox"/> Arthritis (OA, RA)</td> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Reflux (Gerd)</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> HIV</td> <td><input type="checkbox"/> Rheumatic Fever</td> </tr> <tr> <td><input type="checkbox"/> Back, Hip, Knee Pain</td> <td><input type="checkbox"/> Keloid/Thick Scar</td> <td><input type="checkbox"/> Scarlet Fever</td> </tr> <tr> <td><input type="checkbox"/> Broken Bone/s</td> <td><input type="checkbox"/> Kidney Disease</td> <td><input type="checkbox"/> Sciatica</td> </tr> <tr> <td><input type="checkbox"/> CAD (Cholesterol)</td> <td><input type="checkbox"/> Liver Disease</td> <td><input type="checkbox"/> Scleroderma</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Lung Disease</td> <td><input type="checkbox"/> Sickle Cell</td> </tr> <tr> <td><input type="checkbox"/> Cataracts</td> <td><input type="checkbox"/> Lupus</td> <td><input type="checkbox"/> Sinusitis</td> </tr> <tr> <td><input type="checkbox"/> Crohn's / Colitis</td> <td><input type="checkbox"/> Lyme Disease</td> <td><input type="checkbox"/> Sjogrens</td> </tr> <tr> <td><input type="checkbox"/> Dementia</td> <td><input type="checkbox"/> Macular Degeneration</td> <td><input type="checkbox"/> Spina Bifida</td> </tr> <tr> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> Meniere's Disease</td> <td><input type="checkbox"/> Stomach Ulcer</td> </tr> <tr> <td><input type="checkbox"/> Diabetes ( )</td> <td><input type="checkbox"/> Multiple Sclerosis</td> <td><input type="checkbox"/> Stroke ( )</td> </tr> <tr> <td><input type="checkbox"/> Diverticulosis</td> <td><input type="checkbox"/> Nerve Disorder (RSD)</td> <td><input type="checkbox"/> Thyroid</td> </tr> <tr> <td><input type="checkbox"/> Epilepsy / Seizures</td> <td><input type="checkbox"/> Numbness (Neuropathy)</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Fibromyalgia</td> <td><input type="checkbox"/> Osteoporosis</td> <td><input type="checkbox"/> Ulcer (Skin)</td> </tr> <tr> <td><input type="checkbox"/> Gall Bladder</td> <td><input type="checkbox"/> Paralysis</td> <td><input type="checkbox"/> Vascular Phlebitis (dots)</td> </tr> <tr> <td><input type="checkbox"/> Glaucoma</td> <td><input type="checkbox"/> Parkinson's Disease</td> <td><input type="checkbox"/> Warts</td> </tr> <tr> <td><input type="checkbox"/> Gout</td> <td><input type="checkbox"/> Polio</td> <td></td> </tr> </table> <p>Childhood diseases: <input type="checkbox"/> Measles    <input type="checkbox"/> Mumps    <input type="checkbox"/> Chicken Pox</p> <p>Do you have vascular grafts?                    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Do you have joint / bone implants / screws?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Do you have replacement heart valves?        <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Have you had transfusions?                    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 20%;">Surgery</td> <td style="width: 20%;">Date</td> <td style="width: 60%;">Complications</td> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table> <p>Illness/Explanations _____</p> <p>Primary Care Physician _____</p> <p>Other Physicians _____</p>	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Poor Circulation (PVD)	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psoriasis/Eczema	<input type="checkbox"/> Angina (Chest Pain)	<input type="checkbox"/> Hepatitis (A, B, C, D, E)	<input type="checkbox"/> Psychiatric Disorder	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Raynauds Disease	<input type="checkbox"/> Arthritis (OA, RA)	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Reflux (Gerd)	<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Back, Hip, Knee Pain	<input type="checkbox"/> Keloid/Thick Scar	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Broken Bone/s	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sciatica	<input type="checkbox"/> CAD (Cholesterol)	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Scleroderma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Lupus	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Crohn's / Colitis	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Sjogrens	<input type="checkbox"/> Dementia	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Depression	<input type="checkbox"/> Meniere's Disease	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Diabetes ( )	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Stroke ( )	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Nerve Disorder (RSD)	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Numbness (Neuropathy)	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Ulcer (Skin)	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Vascular Phlebitis (dots)	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Warts	<input type="checkbox"/> Gout	<input type="checkbox"/> Polio		Surgery	Date	Complications													<p>Is there a history of skin reaction or other outward reaction or sickness following any injection or oral or topical administration of:</p> <p><i>Check box that applies</i>                    Yes    No                    <i>If yes, what happens?</i></p> <table style="width: 100%; border: none;"> <tr> <td>Penicillin .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Erythromycin, Biaxin, Z Pack .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Keflex, Ceflin, Ceclor .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Cipro/Levaquin .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Sulfa Drugs (Bactrim) .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Gentamicin .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Aspirin .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Emprin or Tylenol .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Advil, Aleve or Motrin .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Morphine .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Codeine .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Demerol .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Novocaine .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Injectable Steroids (Cortisone) ....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>General/Spinal .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Adhesive Tape .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Shrimp/Shellfish .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Iodine or Merthiolate .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Latex .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Other Drugs/Medications .....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> </table> <p>Allergic to/Reaction _____</p>	Penicillin .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Erythromycin, Biaxin, Z Pack .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Keflex, Ceflin, Ceclor .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cipro/Levaquin .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sulfa Drugs (Bactrim) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gentamicin .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emprin or Tylenol .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Advil, Aleve or Motrin .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Morphine .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Codeine .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Demerol .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Novocaine .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Injectable Steroids (Cortisone) ....	<input type="checkbox"/>	<input type="checkbox"/>	_____	General/Spinal .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Adhesive Tape .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Shrimp/Shellfish .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Iodine or Merthiolate .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Latex .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other Drugs/Medications .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																																															
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Do you smoke now? <input type="checkbox"/> Yes <input type="checkbox"/> No    Packs/Day _____ Years _____																																																																																																																																																															
Did you ever smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No    Packs/Day _____ Years _____																																																																																																																																																															
If you quit, when did you do so? _____																																																																																																																																																															
Caffeine / Coffee / Tea / Soda <input type="checkbox"/> Yes <input type="checkbox"/> No    Amount per day _____																																																																																																																																																															
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Occupation: _____																																																																																																																																																															

# MEDICAL RECORD (continued)



**REVIEW OF SYSTEMS** Check all that apply.

**DENIES**

- CONSTITUTIONAL: weight loss/gain \_\_\_ fever \_\_\_ chills \_\_\_ nausea \_\_\_ vomiting \_\_\_ fatigue \_\_\_ sweating \_\_\_ loss appetite \_\_\_ hunger \_\_\_ thirst \_\_\_
- HEENTM: glasses/contacts \_\_\_ blurred/double vision \_\_\_ retinopathy \_\_\_ hard of hearing \_\_\_ dizziness \_\_\_ nose bleeds \_\_\_
- difficulty chewing/swallowing/speaking \_\_\_ sores \_\_\_ dentures \_\_\_ TMJ \_\_\_ discharge/drainage \_\_\_ implants \_\_\_
- CV: atrial fib \_\_\_ pacemaker \_\_\_ MVP \_\_\_ murmur/palpitations \_\_\_ WPW \_\_\_ CHF \_\_\_ heart attack \_\_\_ septal defect \_\_\_ chest pain \_\_\_ rapid beat \_\_\_
- RESP: shortness of breath \_\_\_ wheezing \_\_\_ coughing \_\_\_ cough blood \_\_\_ on oxygen \_\_\_ pneumonia/pleurisy \_\_\_ bronchitis \_\_\_ emphysema \_\_\_
- G.I.: stomach/abdomen pain \_\_\_ diarrhea \_\_\_ constipation \_\_\_ dark blood stool \_\_\_ irritable bowel \_\_\_ hemorrhoids \_\_\_
- G.U.: frequent/painful/urination/bladder control \_\_\_ kidney stones \_\_\_ infection (UTI) \_\_\_ blood urine \_\_\_ nephropathy \_\_\_
- sex trans dis (STD) \_\_\_ prostate \_\_\_
- MSK: generalized aches and pains \_\_\_ hammertoes \_\_\_ bunions \_\_\_ weakness \_\_\_ scoliosis/kyphosis \_\_\_ muscle cramps \_\_\_
- INTRG: bums \_\_\_ scars \_\_\_ rashes \_\_\_ corns/calluses \_\_\_ ingrown nails \_\_\_ painful nails \_\_\_
- NEURO / PSYCH: balance trouble \_\_\_ difficulty sleeping \_\_\_ confusion \_\_\_ tremors \_\_\_ bipolar \_\_\_ fainting/blackouts \_\_\_ brain disorder \_\_\_
- HEMO / LYMPHATIC: bleeding problem \_\_\_ swelling \_\_\_ bruising \_\_\_

Bottom portion to be filled out by Physician.

## ❖ 3 - Patient's Current Medical Problems

	RIGHT FOOT	LEFT FOOT
		
<p><b>1</b> <b>Complaint</b></p> <p><input type="checkbox"/> Aching</p> <p><input type="checkbox"/> Burning</p> <p><input type="checkbox"/> Discolor</p> <p><input type="checkbox"/> Dull</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Sharp</p> <p><input type="checkbox"/> Shooting</p> <p><input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Tenderness</p> <p><input type="checkbox"/> Throbbing</p> <p><input type="checkbox"/> Tingling</p>	<p>QUALITY: <input type="checkbox"/> MILD (1, 2, 3)    <input type="checkbox"/> MODERATE (4, 5, 6)    <input type="checkbox"/> SEVERE (7, 8, 9, 10)</p> <p>LOCATION: _____</p> <p>DURATION: _____</p> <p>CAUSE (ONSET): _____</p> <p>COURSE: <input type="checkbox"/> Better    <input type="checkbox"/> Worse    <input type="checkbox"/> Same    <input type="checkbox"/> Intermittent</p> <p>AGGRAVATED BY: _____</p> <p>RELIEVED BY: _____</p> <p>CAUSES DIFFICULTY STANDING / WALKING: <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Occasionally</p> <p>PREVIOUS TREATMENTS: _____</p>	
<p><b>2</b> <b>Complaint</b></p> <p><input type="checkbox"/> Aching</p> <p><input type="checkbox"/> Burning</p> <p><input type="checkbox"/> Discolor</p> <p><input type="checkbox"/> Dull</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Sharp</p> <p><input type="checkbox"/> Shooting</p> <p><input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Tenderness</p> <p><input type="checkbox"/> Throbbing</p> <p><input type="checkbox"/> Tingling</p>	<p>QUALITY: <input type="checkbox"/> MILD (1, 2, 3)    <input type="checkbox"/> MODERATE (4, 5, 6)    <input type="checkbox"/> SEVERE (7, 8, 9, 10)</p> <p>LOCATION: _____</p> <p>DURATION: _____</p> <p>CAUSE (ONSET): _____</p> <p>COURSE: <input type="checkbox"/> Better    <input type="checkbox"/> Worse    <input type="checkbox"/> Same    <input type="checkbox"/> Intermittent</p> <p>AGGRAVATED BY: _____</p> <p>RELIEVED BY: _____</p> <p>CAUSES DIFFICULTY STANDING WALKING: <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Occasionally</p> <p>PREVIOUS TREATMENTS: _____</p>	

Valley Podiatry Associates, P.C.

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_