DIPLOMATE, AMERICAN
BOARD OF PODIATRIC SURGERY

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FELLOW, AMERICAN
COLLEGE OF FOOT SURGEONS

PATIENT HISTORY

NAME:______________________________ AGE:____________ TODAY'S DATE:___________________

Referring Doctor:____________________________ Family Doctor:______________________________

Date last seen:______________________________

Describe your foot problem:____

____

____

____

How severe are your symptoms? (rank from 0 = no symptoms to 10 = very severe symptoms)________

How long have you had this problem?____

Shoe Size_______ Current Weight_______ Height_______ Address____________________________

Do you have any of the problems or symptoms listed below? (Check all that apply):

- ❏ Numbness or tingling in the feet? Describe:_____________________________________
- ❏ Chronic foot pain? Describe:____
- ❏ Problems walking? Describe:____
- ❏ Problems with shoes or footwear? Describe:_______________________________

Review of Systems (please circle yes or no for each)

Constitutional			**Psychiatric**		
Fevers	Yes	No	Anxiety	Yes	No
Weight loss	Yes	No	Depression	Yes	No
Eyes			**Hematologic/Lymphatic**		
Loss of visions	Yes	No	Bleeding or bruising tendency	Yes	No
Cardiovascular			Anemia	Yes	No
Shortness of Breath	Yes	No	**Neurological**		
Chest Pain at Rest	Yes	No	Headaches	Yes	No
Respiratory			Seizures	Yes	No
Chronic or frequent cough	Yes	No	**Integumentary**		
Coughing up blood	Yes	No	Rashes	Yes	No
Gastrointestinal			**Musculoskeletal**		
Vomiting	Yes	No	New bone pain	Yes	No
Blood in stools	Yes	No	Muscle weakness	Yes	No

SIGNATURE ON FILE

I authorize payment of medical benefits to Richard M. Hilker, DPM, PC for services rendered and authorize release of information necessary to process this claim. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have.

Signature: ____________________________________ Date: ________________________________

(PLEASE TURN PAGE OVER FOR ADDITIONAL INFORMATION)

Past, Family and Social History

Past History

Do you take aspirin or any aspirin-containing drugs? { } Yes { } No

Do you take Blood thinner (Coumadin, Plavix, etc.) { } Yes { } No

List **all** medications, drugs, or pills that you have taken in the last ten (10) days and dosages, including over the counter and vitamins (we can copy your list)

1. ______________________ 5. ______________________
2. ______________________ 6. ______________________
3. ______________________ 7. ______________________
4. ______________________ 8. ______________________

List all medicines or supplies you are **allergic** to or cannot take (include tape, X-Ray dye, latex, Iodine)

1. ______________________
2. ______________________
3. ______________________

List all previous operations or surgeries

1. ____________ 4. ____________
2. ____________ 5. ____________
3. ____________ 6. ____________

Foot Surgeries

1. ____________
2. ____________
3. ____________

List previous serious illnesses or injuries. Also list ongoing medical problems for with you see a physician

1. ____________ 4. ____________
2. ____________ 5. ____________
3. ____________ 6. ____________

Foot Problems

1. ____________
2. ____________
3. ____________

Do you have diabetes? _____Yes _____No If yes, do you take insulin? _____Yes _____No

Number of years with diabetes ___________

Family History:

Family History of: (Check all that apply)

❑ Arthritis ❑ Bunions ❑ Flatfeet ❑ Muscular Disease

❑ Heart Disease ❑ Hammertoes ❑ Endocrine Disease ❑ Diabetes

❑ Circulation problems in legs or feet

Details:____

Other Family History:______________________________________

Social History:

Occupation:______________________________

Use of tobacco: Non Smoker _____ Current packs/day_____ Years of use_____ Quit Date_____

Use of alcohol: Non Drinker _____ Type_______________ Ounces/day_____ Years of use_____ Quit Date_____

Employment: ❑ Sits at job ❑ Stands at job ❑ Stands and walks at job ❑ Retired

DO YOU HAVE A LIVING WILL? { } YES { } NO ARE YOU PREGNANT? { } YES { } NO

SIGNATURE______________________________ **TODAY'S DATE**____________________