THE FOOT CLINIC
DISEASES AND SURGERY OF THE FOOT & ANKLE
FRANK WILLIAM ZAPPA, DPM

Patient Account Number: _____

☐ **Only changes to the previous history are noted.**

☐ **INITIAL HISTORY** ☐ **UPDATE OF HISTORY** **PATIENT HISTORY AS OF:** ___/___/___

Patient Identification and Contact Information

First Name | M.I. | Last Name | Work Phone | Home Phone | Cell Phone | E-mail

Social Security Number | Sex | Age | Height | Weight | Birth Date

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name | Relation | Day Phone | Evening Phone

PATIENT'S PHARMACY

Name | Address | City | Phone

Comprehensive Patient Medical History

HAVE YOU HAD/BEEN TREATED FOR?

- ☐ Diabetes
- ☐ Corns/Calluses
- ☐ Leg or foot ulcers
- ☐ Broken bones
- ☐ Hammer/Mallet toes
- ☐ Cramps (leg, feet)
- ☐ Lower back pain
- ☐ Gait (walking problems)
- ☐ Childhood foot problems
- ☐ Warts
- ☐ Fungal nails
- ☐ Neuroma
- ☐ Broken ankle
- ☐ Bunions
- ☐ Arch pain
- ☐ Knee pain
- ☐ In-toeing
- ☐ Rash
- ☐ Athlete's foot
- ☐ Ingrown nails
- ☐ Foot numbness
- ☐ Ankle sprain
- ☐ Flat feet
- ☐ High arch feet
- ☐ Heel pain
- ☐ Toe walking
- ☐ **None of these**

DID YOU PREVIOUSLY OR DO YOU NOW WEAR?

Shoe inserts: [Y] [N] Still using them: [Y] [N] Did they help: [Y] [N]
Orthotics: [Y] [N] Still using them: [Y] [N] Did they help: [Y] [N]

The orthotics were obtained from:

◯ Podiatrist ◯ Orthopedist ◯ Physical Therapist
◯ Chiropractor ◯ Another Podiatrist

ARE YOU FIRST STEPS OUT OF BED PAINFUL? [Y] [N] **...THEN SUBSIDES?** [Y] [N]
DO YOU GET LEG CRAMPS DURING THE DAY? [Y] [N] **...AT NIGHT?** [Y] [N]
PERCENT OF WALKING HOURS SPENT ON YOUR FEET? [Y] [N]

LIST THE SPORTS/TYPE OF DANCE YOU ARE ACTIVE IN:

_____

DOES FOOT PAIN LIMIT YOUR DESIRED ACTIVITIES? [Y] [N]
DO YOU HAVE DIFFICULTY WALKING? [Y] [N]
ANY PAIN IN CALVES OR BUTTOCKS WHEN WALKING? [Y] [N]
IS THE PAIN RELIEVED BY STOPPING & STANDING STILL? [Y] [N]

HAVE YOU HAD/BEEN TREATED FOR?

- ☐ Stroke
- ☐ Phlebitis
- ☐ Hepatitis
- ☐ Gout
- ☐ Sciatica
- ☐ Alzheimer's
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Asthma
- ☐ Cancer
- ☐ Other(s): _____
- ☐ Heart attack
- ☐ Vascular disease
- ☐ Poor circulation
- ☐ Liver disease
- ☐ Arthritis
- ☐ Rheumatic fever
- ☐ Keloid/Thick scar
- ☐ Nerve disorder
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Stomach ulcer
- ☐ High blood pressure
- ☐ Heart Condition
- ☐ Headaches
- ☐ Anemia
- ☐ Osteoporosis
- ☐ Lyme's disease
- ☐ Hearing/Ear disorder
- ☐ Psychiatric disorder
- ☐ Thyroid problem
- ☐ Tuberculosis
- ☐ **None of these**

DO YOU HAVE VASCULAR GRAFTS? (IF YES, PLEASE EXPLAIN BELOW) [Y] [N]
DO YOU HAVE JOINT IMPLANTS? (IF YES, PLEASE EXPLAIN BELOW) [Y] [N]
DO YOU HAVE REPLACEMENT HEART VALVES? (IF YES, PLEASE EXPLAIN BELOW) [Y] [N]
ARE YOU NOW UNDER ACTIVE CHEMOTHERAPY? [Y] [N]
HAVE YOU HAD ANY OTHER SERIOUS ILLNESS? (IF YES, PLEASE EXPLAIN BELOW) [Y] [N]
HAVE YOU HAD ANY SURGERY? (IF YES, PLEASE EXPLAIN BELOW) [Y] [N]
HAVE YOU BEEN EVER HOSPITALIZED OR BEEN UNDER MEDICAL CARE OVER 24HRS? (IF YES, PLEASE EXPLAIN BELOW) [Y] [N]

Had surgery for: | On date of: | w/ Complications of:

_____ | _____ | _____
_____ | _____ | _____

LIST RELATIONSHIP TO YOU OF FAMILY MEMBERS WHO HAVE HAD:

Diabetes _____ Foot Problems _____
Arthritis _____ Heart Attack _____
Stroke _____ High blood pressure _____
Cancer _____ Birth defects _____

NUMBER OF CHILDBIRTHS? _____ **ARE YOU CURRENTLY PREGNANT?** [Y] [N]
ARE YOU SLOW TO HEAL AFTER CUTS? [Y] [N]
ANY ABNORMAL BRUISING, BLEEDING OR SCARRING? [Y] [N]
DO YOU SMOKE NOW? [Y] [N] **PACKS/DAY** _____ **YEARS** _____
DID YOU EVER SMOKE? [Y] [N] **PACKS/DAY** _____ **YEARS** _____
IF YOU QUIT, WHEN DID YOU DO SO? _____
ALCOHOLIC BEVERAGES? (circle one) **NONE RARELY MODERATELY DAILY QUIT**
RECREATIONAL DRUGS? (circle one) **NONE RARELY MODERATELY DAILY QUIT**
ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (List below) [Y] [N]
ARE YOU TAKING INSULIN? (If yes, list below) [Y] [N]

LIST: MEDICATIONS	DOSAGE?	HOW OFTEN?	FOR TREATMENT?
_____	_____	[A], ___X/ [D] [W],	_____
_____	_____	[A], ___X/ [D] [W],	_____
_____	_____	[A], ___X/ [D] [W],	_____
_____	_____	[A], ___X/ [D] [W],	_____
_____	_____	[A], ___X/ [D] [W],	_____

ARE YOU TAKING MEDICATIONS AS PRESCRIBED? [Y] [N]

ALLERGIES: IS THERE A HISTORY OF SKIN REACTION OR OTHER OUTWARD REACTION OR SICKNESS FOLLOWING AN INJECTION, ORAL OR TOPICAL ADMINISTRATION OF:

MEDICATIONS:		SYMPTOMS:
Penicillin	[Y] [N]	_____
Other antibiotics	[Y] [N]	_____
Morphine	[Y] [N]	_____
Codeine	[Y] [N]	_____
Demerol	[Y] [N]	_____
Other narcotics	[Y] [N]	_____
Novocaine	[Y] [N]	_____
Other anesthetics	[Y] [N]	_____
Aspirin	[Y] [N]	_____
Empirin, Tylenol	[Y] [N]	_____
Advid, Aleve, Motrin	[Y] [N]	_____
Other pain remedies	[Y] [N]	_____
Sulfa Drugs	[Y] [N]	_____
Adhesive tape	[Y] [N]	_____
Shrimp, Iodine or Mertholiate	[Y] [N]	_____
Any other drugs or meds	[Y] [N]	_____

Others: _____

ANYTHING ELSE YOU WANT TO TELL THE DOCTOR? [Y] [N]

Illnesses/Explanations: _____

PLEASE CONTINUE ON THE NEXT PAGE TO PROVIDE ADDITIONAL DETAIL.

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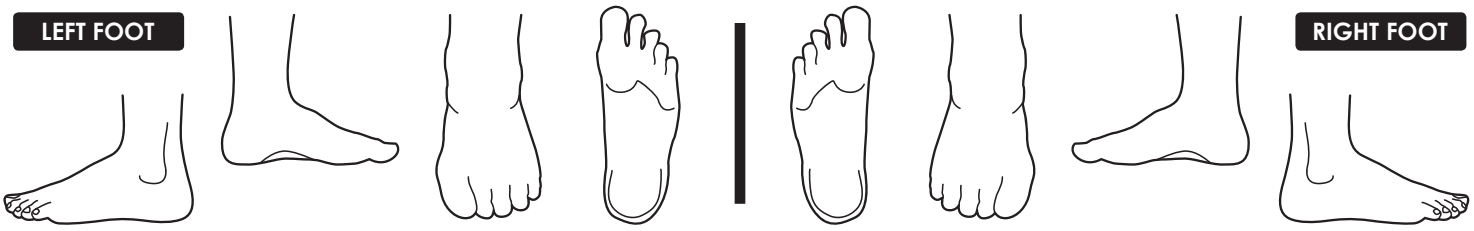
PATIENT HISTORY AS OF: ___/___/___ PATIENT NAME: ___ SSN: ___-___-___ SEX: ___ AGE: ___ DOB: ___

Patient's Current Chief Complaints

Describe 1 or 2 main problems in greater detail below & mark on the diagram below the areas where you have each problem using 1 & 2 to identify them.

LEFT FOOT **RIGHT FOOT**



PLEASE MARK THE LOCATION OF YOU FIRST PROBLEM OR PAIN ON THE DIAGRAMS ABOVE WITH A NUMBER 1 DESCRIBE YOUR PROBLEM BELOW AND ITS CAUSE IF YOU KNOW. PLEASE DESCRIBE ASSOCIATED PAIN IN THE SECTION TO THE RIGHT.

My problem is: ☐ On the left foot ☐ On the right foot ☐ On both feet
It causes me difficulty: ☐ Walking, ☐ Wearing shoes
And, or: _____

Is problem work related? [Y] [N]
Date of injury: _____ Date of report to employer: _____

PAIN: PLEASE INDICATE THE SEVERITY OF PAIN OR DISCOMFORT:
[1] problem [2] problem [3] problem [4] problem [5] problem

My pain/discomfort is:
☐ Shooting pain
☐ Throbbing pain
☐ Sharp pain
☐ Burning pain
☐ Itching
☐ Aching pain
☐ Tenderness
☐ Dull pain
☐ Tingling
☐ Numbness

How long ago did the Problem (pain) start?
_____ ◯ Days ◯ Weeks ◯ Months ◯ Years

The pain from my problem occurs:
☐ While walking and/or ☐ While not walking
☐ and/or _____

Previous medical treatment and/or home remedies?
_____
_____
_____
_____

PLEASE MARK THE LOCATION OF YOU SECOND PROBLEM OR PAIN ON THE DIAGRAMS ABOVE WITH A NUMBER 2 DESCRIBE YOUR PROBLEM BELOW AND ITS CAUSE IF YOU KNOW. PLEASE DESCRIBE ASSOCIATED PAIN IN THE SECTION TO THE RIGHT.

My problem is: ☐ On the left foot ☐ On the right foot ☐ On both feet
It causes me difficulty: ☐ Walking, ☐ Wearing shoes
And, or: _____

Is problem work related? [Y] [N]
Date of injury: _____ Date of report to employer: ____/____/____

PAIN: PLEASE INDICATE THE SEVERITY OF PAIN OR DISCOMFORT:
[1] problem [2] problem [3] problem [4] problem [5] problem

My pain/discomfort is:
☐ Shooting pain
☐ Throbbing pain
☐ Sharp pain
☐ Burning pain
☐ Itching
☐ Aching pain
☐ Tenderness
☐ Dull pain
☐ Tingling
☐ Numbness

How long ago did the Problem (pain) start?
_____ ◯ Days ◯ Weeks ◯ Months ◯ Years

The pain from my problem occurs:
☐ While walking and/or ☐ While not walking
☐ and/or _____

Previous medical treatment and/or home remedies?
_____
_____
_____
_____

Patient's doctors–Please tell us whom to thank and with whom to coordinate your care.

	Physician Name	Phone	City	Last Visit	Referred Me	I was sent or came in for:
Family/Primary	_____	_____	_____	____/____/____	[Y] [N]	[2nd opinion] [Surgical Eval.] [Consult]
Specialist	_____	_____	_____	____/____/____	[Y] [N]	[2nd opinion] [Surgical Eval.] [Consult]
Other Podiatrist	_____	_____	_____	____/____/____	[Y] [N]	[2nd opinion] [Surgical Eval.] [Consult]

For doctor's use only–Observations & comments.

☐ Patient was ◯ Assisted in completing this record by or was ◯ unable to complete without the help of: _____
☐ Translation was done by: _____ in ◯ Spanish, or ◯ _____
☐ Additional information† obtained from: ◯ Family/Care givers, and/or ◯ Physician(s) _____
☐ Lab reports and/or: ☐ Previous medical reports were reviewed. ☐ X-rays† brought by patient from. _____ were reviewed.
† Elaborations: _____

I have reviewed the information provided above _____. ☐ My annotation to patient entries are marked in: _____

Doctor's signature **X** _____ date: ____/____/____ ☐ See additional documentation.