ALL IN ONE FOOTCARE CENTER

Updated September 2025

PATIENT NAME: [LAST, FIRST]
_____ **DOB:** __/__/_____

NEW PATIENT FORM - PODIATRY

Please fill out each question to the best of your ability, thank you! :)

Past Medical History:

Primary Care Provider (PCP): _____

History of : (SELECT ALL THAT APPLY)

- ☐ AIDS/HIV
- ☐ allergies to anesthetics
- ☐ allergies to medicine or drugs
- ☐ anemia
- ☐ angina
- ☐ arthritis
- ☐ artificial heart valves or joints
- ☐ asthma
- ☐ back problems
- ☐ bleeding problems
- ☐ cancer
- ☐ chemical dependency
- ☐ chest pain
- ☐ chronic diarrhea
- ☐ circulatory problems
- ☐ diabetes
- ☐ ear infections
- ☐ chronic
- ☐ eczema
- ☐ epilepsy
- ☐ eye problems
- ☐ fainting
- ☐ gout
- ☐ headaches
- ☐ heart disease
- ☐ hemophilia
- ☐ hepatitis B
- ☐ hepatitis C
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ hypertension
- ☐ jaundice
- ☐ kidney problems
- ☐ liver disease
- ☐ low blood pressure
- ☐ neuropathy
- ☐ phlebitis
- ☐ Parkinson's disease
- ☐ radiation treatment
- ☐ seizures
- ☐ stroke
- ☐ varicose veins
- ☐ vertigo

☐ NONE APPLICABLE

Family History:

Father (Please select all that apply):

- ☐ cancer
- ☐ cardiovascular disease
- ☐ diabetes
- ☐ gastrointestinal disorders
- ☐ kidney disease
- ☐ lung disease
- ☐ musculoskeletal problems
- ☐ neurological disorders
- ☐ rheumatologic disorders

Mother (Please select all that apply):

- ☐ cancer
- ☐ cardiovascular disease
- ☐ diabetes
- ☐ gastrointestinal disorders
- ☐ kidney disease
- ☐ lung disease
- ☐ musculoskeletal problems
- ☐ neurological disorders
- ☐ rheumatologic disorder

Household:

Marital Status: (Circle One) Single Married Widowed Divorced Not Answered

Tobacco Use/Smoking Screening:

Tobacco use: (Circle One)

current smoker current every day smoker current some day smoker Smoker current status unknown former smoker

nonsmoker unknown if ever smoked light tobacco smoker heavy tobacco smoker Uses tobacco in other forms

When did you start smoking? (Year) _____

How often do you smoke cigarettes? (Circle One) every day some days, but not every day

How many cigarettes a day do you smoke? (Circle One) 5 or less 6-10 11-20 21-30 31 or more

How long has it been since you last smoked? (Circle One)

< 1 month 1-3 months 3-6 months 6-12 months 1-5 years 5-10 years > 10 years

Alcohol Screening:

Did you have a drink containing alcohol in the past year? (Circle One) Yes No

How often did you have a drink containing alcohol in the past year? (Circle One)

Never Monthly or less 2 to 4 times a month 2 to 3 times a week 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year? (Circle One)

1 or 2 drinks 3 or 4 drinks 5 or 6 drinks 7 to 9 drinks 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year? (Circle One)

Never Less than monthly Monthly Weekly Daily or almost daily

Drugs Screening:

Have you used drugs other than those for medical reasons in the past 12 months? (Circle One) Yes No

Review of Systems: (Select all that apply)

Occupation: _____

How often do you exercise? (Circle One)

- ☐ 1-2 times per week
- ☐ 3-4 times per week
- ☐ 5 or more times per week

General / Constitutional

- ☐ Changes in appetite
- ☐ Fatigue
- ☐ Fever
- ☐ Chills

Dermatology

- ☐ Changing moles
- ☐ Dry skin
- ☐ Hives
- ☐ Skin lesion(s)
- ☐ Ulcerations

Respiratory

- ☐ Chest pain
- ☐ Cough
- ☐ Shortness of breath

Neurologic

- ☐ Dizziness
- ☐ Gait abnormality
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Tingling / numbness

Cardiovascular

- ☐ Heart murmur
- ☐ Palpitations

Gastrointestinal

- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea

Musculoskeletal

- ☐ Arthritis / arthralgia
- ☐ Back pain
- ☐ History of gout
- ☐ Joint stiffness
- ☐ Leg cramps
- ☐ Leg swelling
- ☐ Trauma to ankle(s)
- ☐ Trauma to knee(s)

Podiatric

- ☐ Achilles pain
- ☐ Ankle pain
- ☐ Foot pain
- ☐ Sole pain
- ☐ Ball of foot pain
- ☐ Big toe pain
- ☐ Foot swelling
- ☐ Foot numbness