PARNASSUS HEIGHTS PODIATRY GROUP

A Professional Corporation

Diseases & Injuries of the Foot & Ankle

Joel R. Clark, DPM • Jamie Kim, DPM • Colin J. Traynor, DPM

Date: ____________________
Shoe Size: ________________
Height: __________________
Weight: __________________

Race:
- ☐ American Indian
- ☐ African American
- ☐ Asian
- ☐ Native Hawaiian
- ☐ White
- ☐ Unknown/Other: __________

Ethnicity:
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown/Other: __________
- ☐ Decline to answer

Describe the problem and the DATE your symptoms began: **Side Affected:** ☐ Right ☐ Left ☐ Both

____
____
____

Have any tests been done? ☐ X-rays ☐ CT scan ☐ MRI ☐ EMG ☐ NCT ☐ Other: __________

Have you ever had or do you presently suffer from:

1) Seizures ☐Yes ☐No
2) Stroke ☐Yes ☐No
3) Cardiac/Heart Problems ☐Yes ☐No
4) High Blood Pressure ☐Yes ☐No
5) Respiratory Problems ☐Yes ☐No
6) Cancer ☐Yes ☐No
   If yes, site: ____________________
7) Diabetes ☐Yes ☐No
8) HIV ☐Yes ☐No
9) Hepatitis/Jaundice ☐Yes ☐No
10) GERD ☐Yes ☐No
11) Ulcer/GI Problems ☐Yes ☐No
12) Thyroid Disorder ☐Yes ☐No
13) Anxiety/Depression ☐Yes ☐No
14) Blood Clots/Phlebitis ☐Yes ☐No
15) Bleeding Disorder ☐Yes ☐No
16) Kidney/Bladder Infection ☐Yes ☐No
17) Psoriasis/Skin Rash ☐Yes ☐No
18) Arthritis ☐Yes ☐No
19) Have you had Cortisone? ☐Yes ☐No
   If yes, site: ____________________
20) Reaction to Anesthesia ☐Yes ☐No
   If yes, reaction: ____________________
21) Smoke Cigarettes ☐Yes ☐No
   If yes, amount: ____________________
22) Drink Alcohol ☐Yes ☐No
   If yes, amount: ____________________
23) Use Recreational Drugs ☐Yes ☐No
   If yes, type: ____________________
   If yes, frequency: ____________________

List any other medical conditions not mentioned above:

____
____
____

List all MEDICATIONS you are presenting taking:

____
____
____
____

List all ALLERGIES:

____
____
____

List all past surgeries (include dates):

____
____
____

Review of systems:

Lower back pain?	☐Yes ☐No
Recent fevers, unintentional weight loss?	☐Yes ☐No
Recent vision changes, double vision?	☐Yes ☐No
Chest pain, palpitations?	☐Yes ☐No
Shortness of breath, wheezing, coughing after exercise?	☐Yes ☐No
Nausea, vomiting?	☐Yes ☐No
New rashes?	☐Yes ☐No
Dizziness, weakness, numbness, tingling?	☐Yes ☐No
Depressed mood, sleep problems, anxiety?	☐Yes ☐No
Joint swelling?	☐Yes ☐No
For female patients:	
Are you pregnant, trying to get pregnant or breastfeeding?	☐Yes ☐No

Patient Signature: ______________________ **Date:** ______________________

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