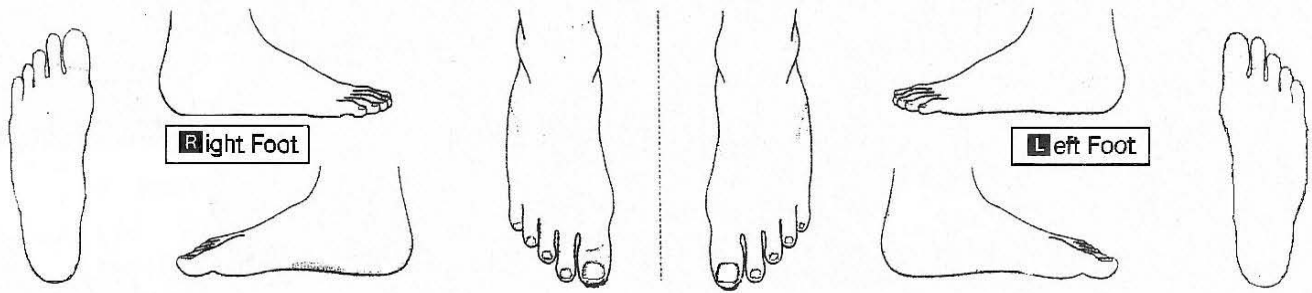


Patient Name: _____ SSN _____ / _____ / _____

PODIATRY PROBLEM:

Please mark or circle the diagram below where you are having your problems:



Primary Problem:

How long ago did your problem start? _____

Was it caused by an injury? Yes/No Was the injury work related? Yes/No

Pain occurs when walking? Yes/No Not walking? Yes/No All the time? Yes/No At night? Yes/No

What makes the problem worse? _____

What makes the problem better? _____

Does the pain travel anywhere? _____

Describe the Pain (circle all that apply) Dull, Ache, Burning, Throbbing, Itch, Tender, Tingle, Numb?

What have you done so far to treat the problem? _____

Secondary Problem(s):

How long ago did it start? _____

Was it caused by an injury? Yes/No Was the injury work related? Yes/No

Pain occurs when walking? Yes/No Not walking? Yes/No All the time? Yes/No At night? Yes/No

What makes the problem worse? _____

What makes the problem better? _____

Does the pain travel anywhere? _____

Describe the Pain (circle all that apply) Dull, Ache, Burning, Throbbing, Itch, Tender, Tingle, Numb?

What have you done so far to treat the problem? _____

Is there anything else you wish to discuss with the podiatrist about your foot/ankle problem(s)? _____

For Doctor's use only

Patient was aided in completion of the records by _____

Additional information was obtained by _____

Guardian(s) present with patient _____

The following were reviewed:

Lab reports _____

Previous Medical Records _____

Radiological findings _____

Signature: _____ Date: _____