

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Describe your foot problem: \_\_\_\_\_

When did this begin? \_\_\_\_\_  days  weeks  months  years

Which foot?  right  left Do you have pain?  yes  no

Where?  toes  foot [top/bottom]  heel [bottom/back]  ankle [front/back/inside/outside]

When?  resting  walking  running  morning  night  in shoes  barefoot

Pain is best described as?  burning  tingling  sharp  dull  throbbing  aching  electrical  numbness

Does the pain travel?  yes  no If yes describe: \_\_\_\_\_

Do you have swelling?  yes  no In my:  toe  foot  ankle  leg When?  AM  PM  all day

Treatment attempted? \_\_\_\_\_

Surgery on this problem?  Yes  No If yes describe: \_\_\_\_\_

Medications	Illness
Allergies	Reaction
Surgeries	Date

I drink  beer  wine  other, \_\_\_\_\_ times per  day  week  month, usually \_\_\_\_\_ number of drinks

I smoke \_\_\_\_\_ number of  cigarettes  cigars  other, for the past \_\_\_\_\_ number of  months  years

Have you used  inhaled or  injected drugs?  No Do you still use?  Yes  No, clean since \_\_\_\_\_