☐ Referral Pt from:

DOCUFORMS™ POD-2010
A Confidential Medical Office Record

☐ Only Changes To The Previous History Information Are Noted

1 PATIENT IDENTIFICATION AND CONTACT INFORMATION

Patient Acct # Staff Entry

First Name: MI: Last Name:

Your type of Job Activity / Occupation:

☐ I prefer to be addressed as: Mr. Mrs. Miss Ms. Dr.

Last 4 digits of Social Sec. #: Sex M / F Age Birth Date: / /

Shoe Size: Weight: Height:

☐ I prefer to be addressed by: ○ First Name ○ Nick Name:

Phone Numbers For Contacting You:
Day: ( ) -
Evening: ( ) -
Cell/Pager: ( ) -

In Case of Emergency, Please Call:
Day: ( ) -
Evening: ( ) -

Please Provide Your Preferred Pharmacy:
Street / City:
Day Ph: ( ) -

☐ INITIAL HISTORY

2 COMPREHENSIVE PATIENT MEDICAL HISTORY

ROS/PFSH

Have you had/been treated for:
☐ Warts ☐ Athlete's Foot
☐ Corns/Calluses ☐ Fungal Nails ☐ Ingrown nails
☐ Leg or Foot Ulcers ☐ Neuroma ☐ Foot Numbness
☐ Broken foot bone(s) ☐ Broken Ankle ☐ Ankle sprain
☐ Hammer/Mallet toes ☐ Bunions ☐ Flat feet
☐ Cramps in legs/feet ☐ Arc h pain ☐ High arch feet
☐ Lower back pain ☐ Knee pain ☐ Heel pain
☐ Gait (Walking) problems ☐ In-toeing ☐ Toe walking
☐ Childhood foot problems ☐ Rash ☐ *NONE of these*

Did you previously or do you now wear:
Shoe inserts? N Y Still using them? N Y Do or did they help? N Y
Orthotics? N Y Still using them? N Y Do or did they help? N Y

The orthotics were obtained from: ○ Another Podiatrist ○ An Orthopedist ○ A Physical Therapist ○ A Chiropractor ○ Other:

Are your first steps out of bed painful? N Y ... then subsides? N Y
Do you get leg cramps ...during the Day? N Y ...at Night? N Y
Percent of waking hours spent on your feet? 20% 40% 60% 80% 100%
List the sports/type of dance your are active in:

Does foot pain limit your desired activities? ☐ No ☐ Yes
Do you have any difficulty in walking? ☐ No ☐ Yes
Any pain in calves or buttocks when walking? ☐ No ☐ Yes
Is the pain relieved by stopping & standing still? ☐ No ☐ Yes

Do you have or have you ever been treated for:
☐ Stroke ☐ Heart Attack ☐ High Blood Pressure
☐ Phlebitis ☐ Vascular Disease ☐ A Heart Condition
☐ Anemia ☐ Poor Circulation ☐ Eyes:Glaucoma/Macular Degn.
☐ Diabetes ☐ Kidney Disease ☐ Keloid/Thick Scar
☐ Gout ☐ Osteoporosis ☐ Alzheimer's
☐ Sciatica ☐ Lyme's Disease ☐ Rheumatic Fever
☐ Arthritis ☐ Headaches ☐ Hearing/Ear Disorder
☐ Epilepsy ☐ Nerve Disorder ☐ Psychiatric Disorder
☐ Asthma ☐ Lung Disease ☐ Tuberculosis
☐ Hepatitis ☐ Liver Disease ☐ Thyroid Problem
☐ Dark Urine ☐ Chronic Light Stool ☐ Unexplained Weight Loss
☐ Cancer ☐ Stomach Ulcer ☐ High Cholesterol
☐ *NONE of these* ☐ Other(s):

Do you have vascular grafts? *(If yes, explain below)* ☐ No ☐ Yes
Do you have joint implants? *(If yes, explain below)* ☐ No ☐ Yes
Do you have replacement heart valves? ☐ No ☐ Yes
Are you now under active chemotherapy? ☐ No ☐ Yes
Have you had any other serious illness? *(List below)* ☐ No ☐ Yes
Have you had any surgery? *(If yes, explain below)* ☐ No ☐ Yes
Have you ever been hospitalized or been under medical care over 24 hrs? *(If yes, explain below)* ☐ No ☐ Yes

I 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

Have you been out of the country or state recently? ☐ No ☐ Yes
# of childbirths ___ Are you currently pregnant? ☐ No ☐ Yes
Are you slow to heal after cuts? ☐ No ☐ Yes
Any abnormal bruising, bleeding or scarring? ☐ No ☐ Yes
Did you ever smoke? ☐ No ☐ Yes Packs/day? ___ Years? ___
Do you smoke now? ☐ No ☐ Yes Packs/day? ___ Years? ___
If you quit, when did you do so?
Alcoholic beverages? ○ None ○ Rarely ○ Moderately ○ Daily ○ Quit
Recreational Drugs? ○ None ○ Rarely ○ Moderately ○ Daily ○ Quit
Please mark if you take vitamins or supplements that contain ○ *garlic,* ○ *Gingko biloba,* ○ *echinacea,* ○ *ginseng or* ○ *St. John's Wort*
Are you currently taking any medications? List below! ☐ No ☐ Yes
Are you taking Insulin? If yes, list below. ☐ No ☐ Yes

When noting frequency: A = As needed, x/ = times per D = day, W = week,

List: Medications	Dose?	How Often?	For Treatment of?
		A, x/ D W,	
		A, x/ D W,	
		A, x/ D W,	
		A, x/ D W,	
		A, x/ D W,	

Are you taking your medications as prescribed? ☐ No ☐ Yes

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

(Check the answer box that applies)	No	Yes	*If yes, what happens?*
Latex, Adhesive tape (circle)	N	Y	
Penicillin	N	Y	
Other antibiotics (list below)	N	Y	
Empirin, Tylenol (if yes, circle)	N	Y	
Aspirin, Advil, Aleve, or Motrin (circle)	N	Y	
Celebrex	N	Y	
Other pain remedies (list below)	N	Y	
Morphine	N	Y	
Codeine	N	Y	
Demerol	N	Y	
Other narcotics (list below)	N	Y	
Novocaine	N	Y	
Other anesthetics (list below)	N	Y	
Sulfa drugs	N	Y	
Shrimp, Iodine, or Merthiolate	N	Y	
Any other drugs or medications	N	Y	

Others:

Anything else that you want to tell the doctor? ☐ No ☐ Yes
Illnesses/Explanations:

☐ UPDATE OF HISTORY TAKEN ___/___/___

PATIENT HISTORY AS OF ___/___/___

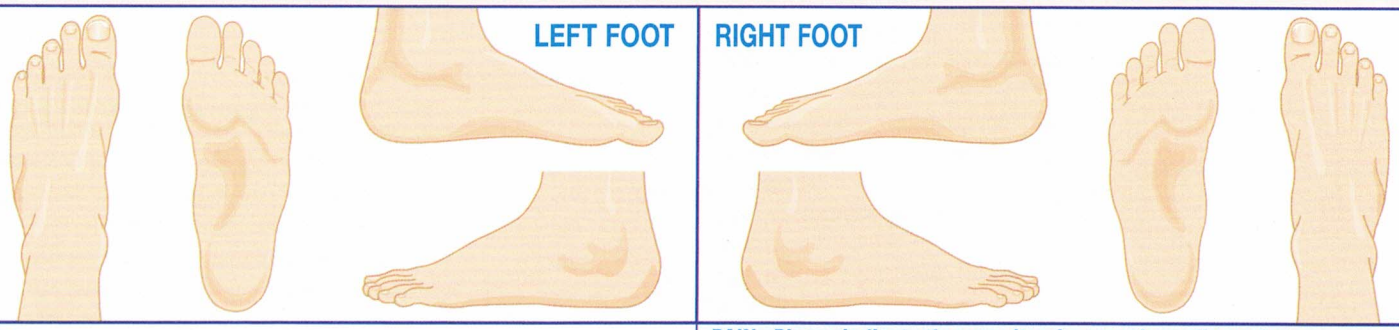
PLEASE CONTINUE ON THE OTHER SIDE TO PROVIDE ADDITIONAL DETAILS.

☐ _____ assisted completion

☐ Only Changes To The Previous History Information Are Noted

3 PATIENT'S CURRENT CHIEF COMPLAINTS CC/HPI

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



1 Please mark the location of your 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 to the right ➡

My 1st problem is on… ☐ Left Foot ☐ Right Foot ☐ Both Feet. ☐ Left Ankle ☐ Right Ankle ☐ Both Ankles.

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 your pain or discomfort:
0 None . . 1 Light . . 2 Moderate . . 3 Strong . . 4 Severe

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 ago

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

Previous medical treatment(s) or home remedies:
_____
_____
_____

2 Please mark the location of your 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 to the right ➡

My 1st problem is on… ☐ Left Foot ☐ Right Foot ☐ Both Feet. ☐ Left Ankle ☐ Right Ankle ☐ Both Ankles.

It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or ...

_____

_____

_____

_____

_____ Is problem work related? Y N

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How long ago did the problem (pain) start?:
_____ ○ days, ○ weeks, ○ months, ○ years ago

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

Previous medical treatment(s) or home remedies:
_____
_____
_____

4 PATIENT'S DOCTORS - PLEASE TELL US WHOM TO THANK AND WITH WHOM TO COORDINATE YOUR CARE

My:	Physician's Name:	Phone Number	City	Date Last Seen	Referred me:	I was sent or came in especially for:		
Family/ Primary				/ /	Y N	2nd Opinion	Surgcl Eval	Consult
Specialist				/ /	Y N	2nd Opinion	Surgcl Eval	Consult
Other Podiatrist				/ /	Y N	2nd Opinion	Surgcl Eval	Consult

5 FOR DOCTOR'S USE - OBSERVATIONS & COMMENTS PLUS ADDITIONAL SPECIFICITY FOR SEC. #2 AND #3

☐ Patient was ○ assisted in completion of this record by or was ○ unable to complete without the help of: _____.

☐ Translation was done by _____ in ○ Spanish, ○ _____.

☐ Additional Information† obtained from ○ Family/Care givers and/or ○ Physician(s) _____

☐ Lab Reports† and/or ☐ Previous Medical Records† were reviewed. ☐ X-rays† brought by patient from _____ were reviewed.

† Elaborations/Disorders/Deformities/Fractures: _____

I have reviewed the information provided above _____. ☐ My annotations to patient's entries are marked in: _____ (INK COLOR)

Doctor's Signature X _____ Date / / MP ☐ See Additional Documentation

Dr Total minutes of Pre-Visit Review

A Confidential Office Medical Record

☐ QA Review by _____ on / /

Dr Total minutes spent w/Pt on Review

2010

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PATIENT HISTORY

Patient Name Last, First, Middle _____

Medical Record # or Last 4 Digits of SSN _____ Sex _____ Age _____ DOB / /