Dr. Richard C. Galperin

Patient Name: _____ Date: _____

Pharmacy: _____ Telephone Number: _____---_____

Family /Referring Doctor_____ Date Last Seen: _____

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left _____

_____

2. **Describe the pain/discomfort:** ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____
3. **When did the pain/discomfort begin?** _____
4. **What makes the pain/discomfort better:** _____
5. **What makes the pain/discomfort worst:** _____
6. **List all medications/herbs/vitamins:** ☐ **NONE** _____

_____

7. **Allergies:** (Describe reaction) ☐ **NONE**

☐ Penicillin _____ ☐ Aspirin _____ ☐ Narcotic Agent / Codeine _____
☐ Anesthesia _____ ☐ Shellfish _____ ☐ Sulfa Drugs _____
☐ Nickel / Metal _____ ☐ Radiographic Contrast Dye _____
☐ Other _____

8. **Past Medical and Family History**

Condition	Self	Family		Condition	Self	Family	
Anemia	☐	☐	_____	Kidney Disease	☐	☐	_____
Anesthetic Reaction	☐	☐	_____	Liver Disease	☐	☐	_____
Arthritis	☐	☐	_____	Mental Retardation	☐	☐	_____
Asthma	☐	☐	_____	Mitral Valve Prolapse	☐	☐	_____
Bleeding Disorders	☐	☐	_____	Multiple Sclerosis	☐	☐	_____
Cancer	☐	☐	_____	Nails Disorders	☐	☐	_____
Circulation Problems	☐	☐	_____	Nerve Disorders	☐	☐	_____
Diabetes Avg Glucose____	☐	☐	_____	Obesity	☐	☐	_____
Epilepsy	☐	☐	_____	Phlebitis	☐	☐	_____
Foot Problem(s)	☐	☐	_____	Pulmonary Disease	☐	☐	_____
Gout	☐	☐	_____	Rheumatic Fever	☐	☐	_____
Heart Disease	☐	☐	_____	STD	☐	☐	_____
Hepatitis	☐	☐	_____	Skin Problems	☐	☐	_____
High Blood Pressure	☐	☐	_____	Stomach/Intest Problems	☐	☐	_____
High Cholesterol	☐	☐	_____	Stroke	☐	☐	_____
HIV/AIDS	☐	☐	_____	Thyroid Disorders	☐	☐	_____
Injury Trauma - Major	☐	☐	_____	Varicose Veins	☐	☐	_____

9. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: _____

10. **Social History:** (Only check what is pertinent to you)

☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits_____
☐ Caffeine Use ☐ Drug use (recreational, IV)

11. **Occupation:** _____ **Is your problem work related?** ☐ Yes ☐ No
12. **Are you currently pregnant?** _____
13. **Height:** _____ **Weight:** **Shoe Size:**

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

onstitutional:	Y	N
Generally do you feel well?	☐	☐
Do you feel fatigued during the day?	☐	☐
Does your problem limit your normal daily activities?	☐	☐
Do you have a fever?	☐	☐

yes:	Y	N
Do you wear glasses or contacts?	☐	☐
Do you have burning or itchy eyes?	☐	☐
Do you have sensitivity to light?	☐	☐
Do you have watering of your eyes?	☐	☐
Are your eyes frequently red?	☐	☐
Do you have eye pain?	☐	☐

ars, nose, mouth & throat:	Y	N
Do you have ringing in your ears?	☐	☐
Do you get nosebleeds?	☐	☐
Do you have difficulty swallowing?	☐	☐

Cardiovascular:	Y	N
Have you noticed your legs or ankles swelling?	☐	☐
Do you have varicose veins?	☐	☐
Do you have cramps in your legs at night or at rest?	☐	☐
Do you have cramps in your legs when walking?	☐	☐
Do your feet feel especially cold?	☐	☐

Respiratory:	Y	N
Do you have chest pain?	☐	☐
Do you have difficulty breathing?	☐	☐
Do you have shortness of breath?	☐	☐
Have you had a cough lasting longer than 3 weeks?	☐	☐

Gastrointestinal:	Y	N
Do you have a loss of increase in appetite?	☐	☐
Do you have a history of stomach ulcers?	☐	☐
Do you have heartburn?	☐	☐
Does Aspirin cause stomach pain?	☐	☐
Do you have bloody or dark stools?	☐	☐

Genitourinary:	Y	N
Do you urinate more frequently than before?	☐	☐
Do you have pain with urination?	☐	☐
Do you have burning with urination?	☐	☐
Have you noticed blood in your urine?	☐	☐

Musculoskeletal:	Y	N
Do you have low back pain?	☐	☐
Do you have pain in your legs?	☐	☐
Do you have foot pain?	☐	☐
Do you have joint pain?	☐	☐
Do you have bone pain?	☐	☐
Do you have general muscle aches or pains?	☐	☐
Have you had swelling in your legs?	☐	☐
Have you had joint swelling or stiffness?	☐	☐
Have you noticed a change in the way you walk?	☐	☐
Is it difficult to climb stairs?	☐	☐
Are you experiencing a loss of strength in your legs?	☐	☐
Have you felt rigidity in your legs?	☐	☐
Do you limp when you walk?	☐	☐
Do your shoes wear out quickly or unevenly?	☐	☐

Integumentary (Skin):	Y	N
Do you have any skin problems?	☐	☐
Is your skin strongly sensitive when exposed to the sun?	☐	☐
Do you have any skin rashes?	☐	☐
Do you have any warts on your feet?	☐	☐
Do you have any moles, lumps, bumps on your skin?	☐	☐
Do you have extremely dry skin or cracking?	☐	☐
Do you have any open skin sores?	☐	☐
Are there unusual areas of discoloration on your skin?	☐	☐
Do you have any corns or calluses on your feet?	☐	☐
Are your nails unusually thick?	☐	☐
Are your nails deformed?	☐	☐
Are your nails ingrown and tender?	☐	☐
Do your nails cause you pain?	☐	☐
Do you have problems with your fingernails?	☐	☐
Do you have noticeable hair loss on your legs or feet?	☐	☐

Neurological	Y	N
Do you ever feel dizzy?	☐	☐
Do you often feel confused or disoriented?	☐	☐
Do you have problems with your balance?	☐	☐
Do you have frequent or reoccurring headaches?	☐	☐
Do you have seizures?	☐	☐
Do you have tremors of your extremities?	☐	☐
Do your legs often feel like they "are going to sleep"?	☐	☐
Do you have numbness in your legs?	☐	☐
-a feeling of burning in your legs?	☐	☐
-cramps or pain in the legs with walking or exercise?	☐	☐
-leg pain that is worse at night or at rest?	☐	☐
-leg pain all the time?	☐	☐
-experience shooting pain down your legs?	☐	☐
-paralysis (complete loss of muscle strength) in legs?	☐	☐

Psychiatric:	Y	N
Do you have a history of psychiatric problems?	☐	☐
Are you subject to mood swings?	☐	☐
Are you under a lot of stress?	☐	☐

Endocrine:	Y	N
Do you urinate more frequently than before?	☐	☐
Are you excessively thirsty?	☐	☐
Do you have a history of bad breath?	☐	☐
Are you experiencing night sweats?	☐	☐
Do you have swollen glands?	☐	☐
Have you had a significant weight change recently?	☐	☐

Hematologic / Lymphatic	Y	N
Do you bruise easily?	☐	☐

Allergic / Immunologic:	Y	N
If you get cut, does it take a long time to heal?	☐	☐
Do you have allergic reactions to medication, foods dye?	☐	☐