

MEDICAL HISTORY

Name _____ Age ____ Height ____ Weight ____ Today's date _____

Which leg, foot or ankle is involved?: Right Left Both Shoe size _____

Please describe the problem: _____

How long have you had this problem? ____ days ____ weeks ____ months ____ years

Rate your pain on a scale of 1-10 (1 being minimal discomfort, 10 being worst pain of your life) _____

Describe your pain: dull achy sharp throbbing burning numbness tingling

Other _____

Is there any history of trauma or surgery to the area? (If yes, describe) _____

What treatments have you or other doctors tried before coming here? _____

What, if anything, makes it better? _____

What makes it worse? _____

Past Medical History Please list all medical conditions you have had (e.g. diabetes, high blood pressure, stroke, etc.): _____

Past Surgical History Please list any surgeries you have had: _____

Medications Please list all medications you take: _____

Allergies Please list all known drug allergies: _____

Check any other allergies: Iodine Shellfish IV dye Latex Tape Other _____

Social History Marital status: M S D W Separated # of children _____

Occupation: _____ # hours on feet each day _____

Do you smoke? No yes __ packs per day for __ years. I smoked for __ years but quit __ years ago.

How much alcohol do you drink? Never occasionally __ drinks per day or __ drinks per week

How much coffee or tea do you drink (not including decaf)? __ cups per day None occasionally

Do you use recreational drugs? yes no If yes, which ones _____

Family History List any medical problems that run in your family (example: mother-diabetes, bother-heart disease, grandfather-kidney failure) _____

Does anyone else in your family or home share this same problem? _____



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Signature _____ Date _____