PATIENT RECORD TODAYS DATE_____

Account #_____ **Please fill out completely** Location: PG 1

Dr. Knecht

Patients full name:

Last_____First_____MI_____ Sex M F

Patient SS #_____ Date of Birth_____

Marital Status S M D W Name of Spouse _____

E-Mail _____

Phone_____Work_____Cell_____

Local Address_____

City_____ State_____ Zip_____

Second or out of state Address_____

City_____State_____Zip_____

Pharmacy # _____

Employer Name _____ Job Title _____

Company Phone _____ Address _____

_____

How did you hear about us?_____ If referred, by whom?_____

Name and **relationship** of Emergency Contact _____

Phone number of Emergency Contact _____

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

Person responsible for services rendered if different than listed above

Name_____ SS#_____

Address_____

Phone_____ DOB _____

Please describe what brings you to the office today? PG 2

_____

_____

How would you describe your pain?

sharp aching throbbin shooting electrical sensation

pins and needles burning cramping numbness

Location of pain or primary complaint:

lower leg ankle achilles tendon heel midfoot arch

forefoot sole of foot ball of foot top of foot big toe lesser toes toenails

other _____

How long has your problems been present?

1 – 3 days 3 – 7 days 1 – 3 weeks 3 – 6 weeks 6 – 8 weeks

3 – 6 months 6 – 9 months 9 – 12 months greater than 1 year

Onset of condition or injury:

gradual onset over time sudden onset from activity or injury

Course/progression of condition:

severe worsening moderate worsening mild worsening steady / unchanging

mild improvement moderate improvement considerable/good improvement

Pain / condition aggravated by:

any weight bearing standing walking running exercise bending

stooping pressure to ball of foot pressure from shoes pressure from jumping

rubbing from clothing

Have you attempted any treatments to relieve your problem?

rest ice elevation change shoe gear over the counter padding

over the counter anti-inflammatory medication (Motrin, Aleve, Tylenol, Aspirin, etc)

in home whirlpool stretching

trimming out toenail yourself applying skin cream

applying topical antibiotic ointment (triple antibiotic, bacitracin, Neosporin, ext)

saw another physician for this problem – instructed to be seen in this office

treated for this condition by another physician

surgery for this condition by another physician

How much improvement and relief have you achieved with previous treatments?

mild improvement moderate improvement considerable improvement

no improvement worsening of condition

Additional factors:

pain worse on 1st morning walking / activity

pain worse when standing and walking after rest

pain worse in shoes

pain worse with any movement

pain worse after running / exercise

pain worse after working on ladder

pain decreases after 1st 15 – 20 minutes of walking

pain decreases after rest

pain decreases after removing shoes

pain decreases after rubbing area

pain decreases after trimming out toenail, but returns in several days

What is your activity level:

sitting standing walking considerable movement/walking retired

Name of Primary Care / Family Physician?

first and last name _____

Date last seen by Primary Care / Family Physician

month_____ day_____ year _____

How did you hear about our office ?

physician _____ family/friend_____ internet newspaper

phone book advertisement other _____

Past medical history:

hypertension/high blood pressure HIV/AIDS hepatitis heart attack/MI insulin dependent diabetes

non insulin dependent diabetes stroke/CVA aneurysm blood clot per diabetic

Respiratory - Do you have:

asthma bronchitis emphysema shortness of breath tuberculosis

valley fever lung cancer collapsed lung/atelectasis pneumonia

Cardiovascular - Do you have:

Hypertension/high blood pressure Myocardial Infarct/Heart attack chest pain angina
palpitations/irregular beats valve prolapse/heart murmur rheumatic fever
angioplasty open heart/bypass surgery pacemaker congestive heart failure

Vascular/Circulation - Do you have?

circulation disorder/decrease leg pain at rest leg pain with walking atherosclerosis/blocked arteries
high cholesterol phlebitis blood clot/deep vein thrombosis varicose veins

Hematological - Have you been anticoagulant with any of the following blood thinners?

anticoagulant medications coumadin heparin aspirin plavix
other blood thinners/ Anticoagulant medications _____

Endocrine - Do you have:

diabetes
thyroid disease

Neurological - Do you have:

seizures stroke tremor change in memory frequent head aches
polio muscle weakness neuro-muscular disease numbness sciatica

Musculoskeletal - Do you have:

Arthritis/degenerative joint disease rheumatoid arthritis gout back pain
hip pain knee pain frequent muscle/tendon pain fibromyalgia

Musculoskeletal - Do you have any of the following joint replacements/prosthesis:

hip knee ankle
hands feet spine

Date of joint replacement:

_____

Integument - Do you have:

skin rashes psoriasis eczema skin cancer hives skin growth
color change to mole or wart change in size of skin growth itching to skin thick scar/keloid

Immunology - Do you have:

HIV Frequent infections/weak immune system chronic fatigue syndrome/Ebstein Barr

Past medical history – injuries/trauma

_____

Have you had any of the following foot surgeries:

toenail bunion hammertoe fracture repair joint fusions

tendon repair/rerouting ankle stabilization arthroscopy fasciotomy

Please list approximate month and year of any surgery listed above:

_____

Past Surgical History: Have you had any of the following surgeries?

heart bypass heart valve repair/replacement appendectomy

gallbladder brain surgery other

Please list approximate month and year of any surgery listed above:

_____

Any other surgeries? (Please specify type of surgery and date)

_____

Any complications/problems with surgery or anesthetics? (please specify)

_____

Previous hospitalization - have you been admitted for:

heart attack stroke pneumonia cancer

infection injury other hospitalizations

Please list approximate month and year of any hospitalization listed above:

_____

Childhood History - Do you ever had:

rheumatic fever measles mumps

chickenpox herpes/cold sores

Social History - Do you:

smoke tobacco drink alcohol smoke marijuana

use cocaine use hallucinogenic drugs use other recreational drugs

If you use other recreational drugs - please list/specify:

_____

Number of drinks per day?

1 2 3 4 5 greater than 5 per day 1 – 3/week per week 4 – 6 /week per week

Occasional use only social drinking only weekend drinking only

If you smoke, number of packs per day?

1/2 1 2 3 4 5 or more

1 -2 pack per week 3 – 4 packs per week occasional smoking social weekends only

Medications - please list medications (including aspirin) currently taking:

_____

_____

_____

Allergies - Do you have allergies to any of the following:

no known allergies or

penicillin erythromycin sulfa codeine

aspirin cortisone adhesive tape

local anesthetics iodine latex

Other allergies to medications - please list severity and type of allergic response:

Mild moderate severe skin rash itching hives G I upset nausea vomiting diarrehea

Wheezing respiratory distress rapid pulse heart palpitations anaphylaxis

What is your height?

_____

What is your weight?

_____

What is your Shoe size and width?

_____

Vitals – What is your Pulse rate per minute? (only if you know your average value – otherwise leave blank) _____

Vitals – What is your Respiratory rate per minute? (only if you know your average value – otherwise leave blank) _____

Vitals – What is your Temperature ? (only if you know your average value – otherwise leave blank) _____

Vitals – What is your Systolic Blood Pressure? (only if you know your average value – otherwise leave blank) _____

Vitals – What is your Diastolic Blood Pressure ? (only if you know your average value – otherwise leave blank) _____

Vitals - What is your most blood sugar level ? (only if you are diabetic)