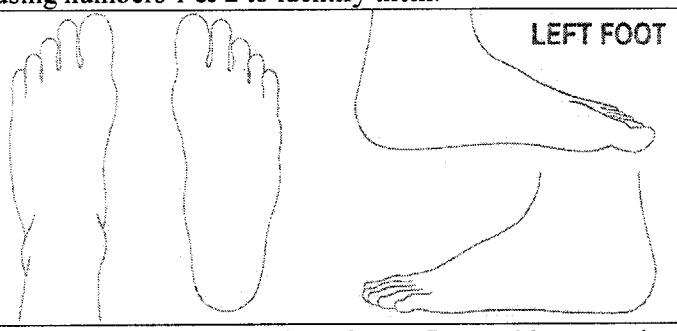
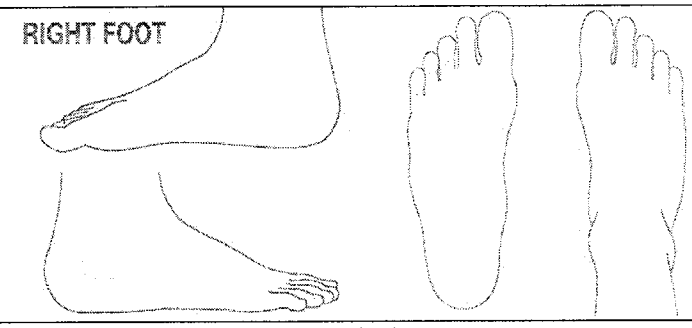
Patient's Current Medical Problems

Describe 1 or 2 main problems in greater detail below & mark 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 first problem is:
☐On Left foot ☐On Right foot☐ On Both feet

Is this problem work related? ☐Yes ☐No

Date of injury: / / Date of report to employer: / /

Pain/ Discomfort is:
☐Shooting Pain
☐Throbbing Pain
☐Sharp Pain
☐Burning Pain
☐Itching
☐Aching Pain
☐Tenderness
☐Dull Pain
☐Tingling
☐Numbness

My Pain /
Discomfort began_____

It occurs when:_____
_____

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

2. Please mark the location of your 2nd problem or pain on the diagrams above with a number 2. Describe your problem below and its cause if you know. Please describe associated pain to the right._____>>>

My first problem is:
☐On Left foot ☐On Right foot☐ On Both feet

Is this problem work related? ☐Yes ☐No

Date of injury: / / Date of report to employer: / /

Pain/ Discomfort is:
☐Shooting Pain
☐Throbbing Pain
☐Sharp Pain
☐Burning Pain
☐Itching
☐Aching Pain
☐Tenderness
☐Dull Pain
☐Tingling
☐Numbness

My Pain /
Discomfort began_____

It occurs when: _____
_____

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

My	Physician's Name	Phone Number	City	Date Last Seen	Referred me	I was sent or came in especially for
Family/ Primary				___/___/_____	Yes/No	2nd Opinion /Surgical eval./ Consult
Specialist				___/___/_____	Yes/No	2nd Opinion /Surgical eval./ Consult
Chiropractor				___/___/_____	Yes/No	2nd Opinion /Surgical eval./ Consult
Other Podiatrist				___/___/_____	Yes/No	2nd Opinion /Surgical eval./ Consult

I was referred by_____, a ☐ Current or Past Patient ☐ Doctor ☐ Nurse or the ☐_____Hospital

I saw your name/ad in: ☐ Insurance Co. Provider List ☐ Yellow Pages ☐ Brochure / Literature ☐ Direct Mail ☐ Just passing by.

☐ The_____Newspaper or Magazine ☐ Dr.'s Lecture ☐ Other_____

E-mail:

Steven A. Rothstein D.P.M.

First Name:	MI:	Last Name:	Employer/ School:
Home Address:			Work/School Address:
City	State	Zip	City / State / Zip
Home Phone:	Work: / Cell:	SS #:	Occupation: / Employed by Employer: ☐wks ☐mths ☐yrs
Sex: M /F	Age:	Birth Date: / /	Shoe Size: / Marital Status: S M W D / Height: / Weight:
In case of emergency, please first call:	Friend or Relative not living with you:		Please provide your preferred Pharmacy:
Day: Evening: Cell:	Day: Evening: Cell:		Day: Evening: Cell:

Have you been treated for:

☐Ankle Injury	☐Arch Pain	☐Low Back Pain
☐Knee Pain	☐Heel Pain	☐Childhood Foot Problem
☐High Arches	☐Flat Feet	☐Broken Foot Bone(s)
☐Bunions	☐Warts	☐Corns/Callouses
☐Ingrown Nails	☐Neuroma	☐Leg or Foot Ulcers
☐Athlete's Foot	☐Rash	☐Hammertoes
☐Numbness	☐Other	

List the sports/type of dance you are active in:

_____

Do your feet hurt at night:	☐Yes ☐No
Do you have any difficulty in walking:	☐Yes ☐No
Do you get leg cramps:	☐Yes ☐No
Any pain in calves or buttocks when walking:	☐Yes ☐No
Is the pain relieved by rest:	☐Yes ☐No

Do you have or have you ever been treated for:

☐Stroke	☐Heart Attack	☐Hepatitis
☐Phlebitis	☐Osteoporosis	☐Vascular Disease
☐AIDS	☐Glaucoma	☐Rheumatic Fever
☐Cancer	☐Epilepsy	☐Psychiatric Disorder
☐Gout	☐Broken Bone	☐Stomach Ulcer
☐Arthritis	☐Lyme's Disease	☐Keloid/Thick Scar
☐Tuberculosis	☐Nerve Disorder	☐Asthma
☐Scarlet Fever	☐Poor Circulation	☐Lung Disease
☐Diabetes	☐Liver Disease	☐A Heart Condition
☐Anemia	☐Kidney Disease	☐None of these
☐Bleeding Disorder	☐High Blood Pressure	☐ Thyroid

Do you have? (please explain below)

Vascular Grafts:	☐Yes ☐No
Joint Implants:	☐Yes ☐No
Replacement Heart Valves:	☐Yes ☐No
Are you now under chemotherapy:	☐Yes ☐No
Have you had any other serious illness:	☐Yes ☐No
Have you ever been hospitalized or been under medical care over 24 hours:	☐Yes ☐No
Have you had any surgery:	☐Yes ☐No
Anything else that you want to tell the doctor:	☐Yes ☐No

Explanations/ Surgeries:

List relationship to you of family members who have had:

Diabetes: _____ Foot Problems: _____
Arthritis: _____ Heart Attack: _____
Stroke: _____ High Blood Pressure: _____
Cancer: _____ Birth Defects: _____
# of childbirths: __ Are you currently pregnant: ☐Yes ☐No
Are you slow to heal after cuts: ☐Yes ☐No
Any abnormal bleeding, bruising or scarring: ☐Yes ☐No
Are you taking insulin: ☐Yes ☐No

Medications:	For What Problem:	For How Long:

Vitamins/ Minerals/ Herbs: _____

Do you smoke now? ☐No ☐Yes Packs/day___Years ___
Did you ever smoke? ☐No ☐Yes Packs/day___Years ___
If you quit, when did you do so? _____
Alcoholic beverages? (circle one)
None Rarely Moderately Daily Quit
Recreational Drugs? (circle one)
None Rarely Moderately Daily Quit

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

	No	Yes	If yes, what occurs?
Penicillin	☐	☐	
Other antibiotics (list below)	☐	☐	
Morphine	☐	☐	
Codeine	☐	☐	
Demerol	☐	☐	
Other narcotics (list below)	☐	☐	
Novocaine	☐	☐	
Other anesthetics	☐	☐	
Aspirin	☐	☐	
Empirin, Tylenol	☐	☐	
Advil, Aleve or Motrin	☐	☐	
Other pain remedies (list below)	☐	☐	
Sulfa Drugs	☐	☐	
Adhesive tape	☐	☐	
Shrimp, iodine or Merthiolate	☐	☐	
Any other drugs or medications	☐	☐	

Allergic to/Reaction: _____