Patient's name: Date:

Height: _____ Weight: _____

Race: _____ ı Decline

Ethnicity: ı Non-Hispanic ı Hispanic ı Decline

Preferred Language: _____

Pain level in feet today (0-10 scale, 10 being worst pain ever and 0 being no pain) :

Review of Systems:

Please circle any problems you are **currently** experiencing. Please circle **NONE** if none apply.

Constitutional: None, fevers, chills, nausea, vomiting or unexplained weight loss

Eyes: None, recent visual changes or eye pain

Ears: None, recent hearing loss, or ear pain

Nose/Mouth/Throat: None, nasal congestion, runny nose, oral lesions, postnasal drip or sore throat

Cardiovascular: None, chest pain, palpitations, lower leg swelling, fainting, or calf pain with walking

Respiratory: None, cough, shortness of breath or wheezing

Gastrointestinal: None, diarrhea, constipation, blood in stools, abdominal pain, vomiting or heartburn

Musculoskeletal: None, arthalgias (joint pain), myalgias (muscle pain) or joint swelling

Skin: None, rash or bothersome skin lesions

Breasts: None, lumps or nipple discharge

Neurological: None, headaches, parasthesias (tingling or numbness), confusion, or gait instability

Psychiatric: None, anxiety or depression

By signing below, I am certifying that this is my/the patient's complete medical history to the best of my knowledge.

Patient or Responsible Party:

X _____

(Signature) *(Print)* *(Date)*