

# HUNTINGTON MEDICAL FOUNDATION

FOR OFFICE USE ONLY

## Podiatry Patient History

Dr# .....

MR# .....

Initial/Update as of .....

Name .....

Age..... Date of birth.....

Email address .....

Who may we thank for referring you?  
.....

Current occupation .....

Reason for visit today .....

Primary Care/Family Doctor:.....

Doctor's phone: .....

Pharmacy Name.....

Pharmacy Phone .....

Date last x-rays taken .....

Where.....

Area of body .....

**What percentage of the time that you are awake are you on your feet? (circle one)**

20% 40% 60% 80% 100%

**List any sports or activities in which you participate:** .....

Do your feet hurt at night? ..... Y N

Do you have any difficulty walking?..... Y N

Do you get leg cramps? ..... Y N

Pain in calves/buttocks when walking? .... Y N

Does rest relieve the pain?.....Y N n/a

**Do you have or have you ever been treated for:**

Alzheimer's Disease

Anemia

Arthritis

Asthma

Blood Clots

Cancer

Cataracts

Depression

Diabetes

Epilepsy

Glaucoma

Gout

Heart Attack

Heart Disease

Hepatitis

High Blood Pressure

Kidney Disease

Liver Disease

Lung Disease

Nerve Disorder

Phlebitis

Psychiatric Disorder

Rheumatic Fever

Scarlet Fever

Stomach Ulcer

Stroke

Trauma

Tumors

**Have you ever had or been treated for:**

Ankle injury

Arch pain

Broken foot bone(s)

Bunions

Calluses

Childhood foot problems

Corns

Flat feet

Foot/nail fungus

Hammertoes

Heel pain

High arch feet

Ingrown nails

Knee pain

Low back pain

Neuroma

Rash

Do you have vascular grafts? ..... Y N

Do you have joint implants? ..... Y N

Do you have replacement heart valves? .... Y N

Are you now under active chemotherapy? Y N

Have you had any other serious illness? .... Y N

Have you ever been hospitalized or needed medical care at home?..... Y N

Please explain:.....

**Have you ever had any of the following operations:**

Appendectomy..... Y N Year .....

Foot or Ankle Surgery..... Y N Year .....

Gallbladder..... Y N Year .....

Heart Surgery..... Y N Year .....

Hemorrhoids..... Y N Year .....

Hip or Knee Surgery..... Y N Year .....

Hysterectomy..... Y N Year .....

Plastic Surgery..... Y N Year .....

Tonsillectomy..... Y N Year .....

Varicose Veins..... Y N Year .....

Have you had any other operations? ..... Y N

Explain:.....

**List family members (children, parent, grandparent, sibling, etc.) who have had:**

Arthritis .....

Birth defects.....

Cancer.....

Diabetes .....

Foot problems .....

Heart attack .....

High blood pressure.....

Stroke .....

CONTINUE ON NEXT PAGE...

Reviewed by.....Date.....

**Podiatry Patient History • Page 2**

Are you slow to heal after cuts? ..... Y N  
Any abnormal bruising or bleeding? ..... Y N  
Are you taking insulin? ..... Y N  
Are you taking a  
blood thinner medication? ..... Y N

**Drugs and supplements**

List prescription drugs and over-the-counter  
drugs, including vitamins and supplements.

Drug.....  
Strength..... For how long? .....  
For what problem? .....

Drug.....  
Strength..... For how long? .....  
For what problem? .....

Drug.....  
Strength..... For how long? .....  
For what problem? .....

Drug.....  
Strength..... For how long? .....  
For what problem? .....

Drug.....  
Strength..... For how long? .....  
For what problem? .....

Drug.....  
Strength..... For how long? .....  
For what problem? .....

Drug.....  
Strength..... For how long? .....  
For what problem? .....

Are you currently pregnant..... Y N  
Are you planning a pregnancy?..... Y N  
Do you smoke now? ..... Y N  
Number of packs per day: ..... for .....years  
Did you ever smoke?..... Y N  
Number of packs per day: ..... for .....years  
If so, when did you quit? .....

Do you drink alcohol? Circle one:  
Never Rarely Moderately Daily Quit  
Do you use recreational drugs? Circle one:  
Never Rarely Moderately Daily Quit

**Allergies**

Have you ever had a skin reaction or other  
reaction/sickness after taking any of the  
following by mouth, injection or topically?

Penicillin or other antibiotics  
Y N Don't know If yes, what happens?

Morphine, Codeine or Demerol  
Y N Don't know If yes, what happens?

Novocain or other anesthetics  
Y N Don't know If yes, what happens?

Aspirin or other pain remedies  
Y N Don't know If yes, what happens?

Sulfa drugs  
Y N Don't know If yes, what happens?  
.....  
.....

Adhesive tape  
Y N Don't know If yes, what happens?  
.....  
.....

Shrimp or Iodine  
Y N Don't know If yes, what happens?  
.....  
.....

Any other drug, medication, or treatment?  
Y N Don't know If yes, please list  
.....  
.....

If yes, what happens?  
.....  
.....

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