Sheboygan Foot Care

Steven Wolfington, DPM, FACFAS

Welcome to our practice!

Please take a moment to complete the following questions as thoroughly as possible. This will enable us to provide you with the utmost in professional podiatric treatment. If you need any assistance in completing your forms, please do not hesitate to inquire at the front desk. We are here to make your visit a pleasant experience.

How were you referred to our office? _____

Patient Information:

Name: _____ Male / Female
First M.I. Last Please circle one

Address: _____
Street Address Apt # City State Zip

Phone: Home ( ) _____ Work ( ) _____
Birthdate: _____ Age: _____ SS# _____-____-_____ Marital Status: _____
Employer: _____ Occupation: _____
Employer Address: _____
Spouse or Parent's Name: _____

In Case of Emergency, Contact:

Name: _____ Relationship: _____
Phone: Home: ( ) _____ Work ( ) _____

Responsible Party (if other than patient):

Name: _____
First M.I. Last

Address: _____
Street Address Apt # City State Zip

Phone: Home ( ) _____ Work ( ) _____
Birth date: _____ Age: _____ SS# _____-____-_____ Marital Status: _____
Employer: _____ Occupation: _____
Employer Address: _____

Primary Care Physician or Medical Doctor:

Name: _____ Phone # ( ) _____
When was your last visit with your Primary Care Physician/MD? Month Year
Patient/Guardian Signature: ___ _____ _____ Date: _____

How Did You Hear About The Practice? (Circle One)

Internet/Google_____ Facebook_____
Friend/Family_____ Insurance Company_____
Doctor Referral (who?)_____
Other_____

630 Riverfront Dr STE 202
Sheboygan, WI 53081
(920) 457-6104

Sheboygan Foot Care, LLC
Medical History

Name: _____ Date: _____
Birth date: _____ Age: _____ Sex: _____ Height: _____ Weight: _____
Shoe Size: _____ Type Most Often Worn: Dress Casual Activity Level: High Average Low

Please Circle "Y"es or "N"o to indicate if you have or have had any of the following:

AIDS/HIV	Y	N
Anemia/ "Low Blood"	Y	N
Arthritis	Y	N
Artificial Heart Valves	Y	N
Artificial Joints	Y	N
Back Problems	Y	N
Bleeding Disorders	Y	N
Blood Clots	Y	N
Cancer	Y	N
Cardiac Arythmia	Y	N
Chemical Dependency	Y	N
Chronic Cough	Y	N
Congestive Heart Failure	Y	N
Coronary Artery Disease	Y	N
Diabetes	Y	N
Depression	Y	N
Eye Problems	Y	N
Epilepsy/Seizure Disorder	Y	N
Gout	Y	N
Headaches	Y	N
Hemophilia	Y	N
Hepatitis	Y	N
High Blood Pressure	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Nervous Problems	Y	N
Phlebitis	Y	N
Psychiatric Care	Y	N
Radiation Treatment	Y	N
Rheumatic Fever	Y	N
Stomach Ulcer/Reflux	Y	N
Stroke	Y	N
Thyroid Disease	Y	N
Tuberculosis	Y	N

For Women:	Are you pregnant?	Y	N
	Are you presently nursing?	Y	N
	Date of Last Menstrual Period: _____		
	Do you take hormone supplements?	Y	N
	Have you ever been diagnosed with osteoporosis?	Y	N

MEDICATIONS: Include prescription, over the counter, and vitamins:

_____

_____

_____

_____

ALLERGIES: Please indicate if you have an allergy to the following:

Adhesive Tape	Y	N	Intravenous Dyes	Y	N	Seafood/Shellfish	Y	N
Aspirin	Y	N	Latex Rubber	Y	N	Soy/Egg Products	Y	N
Codeine	Y	N	Local Anesthetics	Y	N	Sulfa Drugs	Y	N
Demerol	Y	N	Novocaine	Y	N	Other: _____		
Iodine	Y	N	Penicillin	Y	N	_____		

Pharmacy Name: _____

Pharmacy Phone: _____

Sheboygan Foot Care, LLC

Name: _____ Date: _____

Surgical History

Please circle "Y"es or "N"o if you have ever had any of the following:

Appendectomy	Y	N	Mastectomy/Lumpectomy	Y	N
Cataracts/Eye Surgery	Y	N	Surgical Repair of Broken Bones	Y	N
Gall Bladder	Y	N	Reconstructive/Plastic Surgery	Y	N
Heart Bypass	Y	N	Surgery on Lungs	Y	N
Heart Valve Replacement	Y	N	Surgery for Ulcers	Y	N
Hysterectomy	Y	N	Transplant (Organ)	Y	N
Hip Replacement	Y	N	Tubal Ligation	Y	N
Knee Replacement	Y	N			

Other: _____

Have you ever healed with thick, disfigured, or keloid scars?	Y	N
Have you ever had any problems with slow healing of surgical incisions?	Y	N
Have you ever had a blood transfusion?	Y	N
Have you ever had any problems with anesthesia in the past?	Y	N
Is there a history in your family of malignant hyperthermia with anesthesia?	Y	N
Do you routinely take aspirin, over-the-counter anti-inflammatories, or anticoagulants?	Y	N

Family History

Please circle "Y"es or "N"o if anyone in your family has (or has had) and your relationship (i.e., mom, dad, aunt, brother, etc):

Arthritis (Degenerative)	Y	N	_____	High Blood Pressure	Y	N	_____
Arthritis (Rheumatoid)	Y	N	_____	Liver Disease	Y	N	_____
Bleeding Disorders	Y	N	_____	Nerve Disease	Y	N	_____
Cancer	Y	N	_____	Stroke	Y	N	_____
Diabetes	Y	N	_____	Ulcers	Y	N	_____
Gout	Y	N	_____	Foot Problems	Y	N	_____
Heart Disease	Y	N	_____	Other			_____

Personal History

Do you use tobacco products? Y N

Packs/Day _____ Years Smoked _____

Cigars/Day _____ Pipe _____

Chewing Tobacco? Y N

Do you drink alcohol products? Y N

How much do you drink? _____

How often do you drink? _____

If you quit, how long has it been since your last smoke? _____

Do you currently use, or have used in the past, any substance or any prescription narcotic in excess that may injure or may have contributed to any health problems? Y N

Occupation: _____

Approximately how many hours a day do you spend on your feet in relation to your occupation? _____

Are you required to wear certain types of shoes at work? _____

Activities:

Do you actively participate in a workout regimen? Y N

How frequently do you work out? _____

Do you walk, run or jog? (please circle) How often and for how long? (time, distance): _____

What sports do you participate in? _____

Sheboygan Foot Care, LLC
Review of Symptoms

Please indicate any personal history below:

- Constitutional Symptoms
Good general health lately Y N
Recent weight change Y N
Fever Y N
Fatigue Y N
Headaches Y N

- Eyes
Eye disease or injury Y N
Wear glasses/contact lens Y N
Blurred or double vision Y N

- Ears/Nose/Mouth/Throat
Hearing loss or ringing Y N
Earaches or drainage Y N
Chronic sinus problems Y N
Nose bleeds Y N
Mouth sores Y N
Bleeding gums Y N
Bad breath or bad taste Y N
Sore throat or voice change Y N
Swollen glands in neck Y N

- Cardiovascular
Heart trouble Y N
Chest pain / angina pectoris Y N
Palpitation Y N
Shortness of breath with walking Or lying flat Y N
Swelling of feet/ankles/hands Y N

- Respiratory
Chronic or frequent coughs Y N
Spitting up blood Y N
Shortness of breath Y N
Wheezing Y N

- Gastrointestinal
Loss of appetite Y N
Change in bowel movement Y N
Nausea or vomiting Y N
Frequent diarrhea Y N
Painful bowel movements Or constipation Y N
Rectal bleeding or blood In stool Y N
Abdominal pain Y N

- Genitourinary
Frequent urination Y N
Burning or painful urination Y N
Blood in urine Y N
Change in force of stream when urinating Y N
Incontinence or dribbling Y N
Kidney Stones Y N
Sexual difficulty Y N
Male-testicle pain Y N
Female-pain with periods Y N
Female-irregular periods Y N
Female-vaginal discharge Y N
Female-# of pregnancies _____
Female-# of miscarriages _____
Female-date of last pap smear _____

- Musculoskeletal
Joint Pain Y N
Joint stiffness or swelling Y N
Weakness of muscles or joints Y N
Muscle pain or cramps Y N
Back pain Y N
Cold extremities Y N
Difficulty in walking Y N

- Integumentary (skin, breast)
Rash or itching Y N
Change in skin color Y N
Change in hair or nails Y N
Varicose veins Y N
Breast pain Y N
Breast lump Y N
Breast discharge Y N

- Neurological
Frequent or recurring headaches Y N
Light headed or dizzy Y N
Convulsions or seizures Y N
Numbness or tingling Y N
Tremors Y N
Paralysis Y N
Head injury Y N

- Psychiatric
Memory Loss or Confusion Y N
Nervousness Y N
Depression Y N
Insomnia Y N

- Endocrine
Glandular or hormone problem Y N
Excessive thirst or urination Y N
Heat or cold intolerance Y N
Skin becoming dryer Y N
Change in hat or glove size Y N

- Hematologic/Lymphatic
Slow to heal after cuts Y N
Bleeding or bruising tendency Y N
Anemia Y N
Phlebitis Y N
Past transfusion Y N
Enlarged glands Y N

-Hepatic System
Cirrhosis Y N
Hepatitis Y N
Abnormal liver enzymes Y N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

Patient/Guardian Signature: _____ Date: _____

Sheboygan Foot Care, LLC
History of Foot Problems

What specific problem with your foot/feet brings you to our office today? _____
_____
_____

If the problem is related to an injury or accident, please describe what happened: _____
_____
_____

How would you describe the pain/discomfort you are experiencing (e.g. sharp stabbing, dull aching, burning, electrical shocks, radiating, etc….)? _____
_____

How would you rate your pain/discomfort on a scale of 1 to 10, with 1 being the least and 10 the worst?
Please circle: 1 2 3 4 5 6 7 8 9 10
Where on your foot/feet is the pain located? _____
When did this problem first start? How long have you had this problem? _____
Did this problem develop over a period of time, or was it quite sudden? _____
Has this problem stayed the same, improved, or worsened since it started? _____
What are some things that you do that make the problem worse? _____
_____
Is the problem worse in the morning or at the end of the day? _____
Does resting the foot relieve the pain/discomfort? Y N
Is the problem worse in certain shoes? Y N If yes, what kind? _____
Do you have pain while in bed? Y N
Is the pain worse while lying down? Y N
Does the pain wake you from your sleep? Y N
Have you seen a different physician for this problem? Y N If yes, what treatments were done? _____
Have you taken any over the counter or prescribed medications? Y N If yes, which ones? _____
_____
Have the medications provided any relief? Y N
Has this problem affected either your ability to work, enjoy your sports/hobbies, or carry on your usual daily routine? Y N Please explain: _____
Have you ever had foot surgery? Y N If yes, please tell us what was done and which foot was involved: _____

I certify that the above information is accurate and true to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Sheboygan Foot Care

Name: _____ DOB: _____ Date_____

Difficulty on walking surfaces (circle one)

1. No difficulty walking on any surface
2. Some difficulty with uneven surfaces, stairs, ladders or inclines
3. Severe difficulty with uneven surfaces, stairs, ladders or incline.

What are the associated features of your foot/ankle pain?

L □ R □ Keeps me from sleeping at night
L □ R □ Frequently awakes me from sleep
L □ R □ Stiffness
L □ R □ Swelling
L □ R □ Catching
L □ R □ Locking
L □ R □ Giving away
L □ R □ It causes me to fall
L □ R □ Limping
L □ R □ Grinding
L □ R □ Decreased range of motion
L □ R □ Difficulty doing housework
L □ R □ Difficulty with sports activities
L □ R □ Difficulty walking a distance
L □ R □ Other:

_____

Functional Limitations (circle one)

1. No limitations or support devices needed
2. Limited recreational activities, no cane required
3. Limited daily and recreational activities, cane required
4. Severe limitation of daily and recreational activities requiring walker, crutches, wheelchair, brace

Have you had physical therapy for your foot/ankle?

Yes □ **(if yes, when?)**
No □
L_____

R_____

What previous diagnostic tests have you had on your foot/ankle?

L □ R □ None
L □ R □ Plain radiographs
L □ R □ MRI
L □ R □ CT
L □ R □ Ultrasound
L □ R □ Other:

_____

Have you had any previous surgeries on your foot/ankle?

□Yes □ No

(yes, list the surgeries for each and when they were performed?

_____

_____

What medications have you taken? (mark a P for those used in PAST) (mark a C for those used CURRENTLY)

_____None
_____Tylenol
_____Aspirin
_____Ibuprofen/Motrin/Advil
_____Aleve/Naprosyn/Naproxyn
_____Mobic/Meloxicam
_____Celebrex
_____Other NSAID: _____

_____Ultram/Tramadol/Ultracet
_____Narcotic:
_____Cortisone injection
_____Other: _____

What initially brought on your foot/ankle pain?

L □ R □ Not sure
L □ R □ Trauma
Other:

_____

How would you characterize your foot/ankle problem?

L □ R □ An inconvenience
L □ R □ More than an inconvenience
L □ R □ Disabling

Sheboygan Foot Care

Patient Consent for Medical Photography/Videography

Patient Name: _____ D.O.B_____ Date:_____

□ Check here if minor or unable to provide consent:

Name of Guardian or legal representative for Minor patient:_____

I consent for medical photographs or videotaping to be made of my foot/ankle or my child's foot/ankle (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, publication, or advertisement. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the Office, _____. I waive the right of prior approval and hereby release Dr._____ and his practice and any associated staff members from any and all claims for damages of any kind based on the use of my photo information contained.

By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Release.

1) I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

   _____ (Signature) _____ (Witness)

2) I agree for my image to be shown for teaching purposes AND to be used for my medical record but not for medical publication:

   _____ (Signature) _____ (Witness)

3) I agree to use of my image for medical records ONLY:

   _____ (Signature) _____ (Witness)

Sheboygan Foot Care
630 Riverfront Drive Suite 202
Sheboygan, Wisconsin 53081
(920) 457-6104