

***LEGAL NOTICE/DISCLAIMER***

***The information contained in this document does not establish a standard of care, nor does it constitute legal advice. The information is for general informational purposes only and is written from a risk management perspective to aid in reducing professional liability exposure. Please review this document for applicability to your specific practice. You are encouraged to consult with your personal attorney for legal advice, as specific legal requirements may vary from state to state.***

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**ACKNOWLEDGMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES**

**I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.**

\_\_\_\_\_  
**Patient Name (please print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Authorized Representative (if applicable)**

\_\_\_\_\_  
**Signature**

Below please list any and all persons who are authorized to receive your personal health information. No information will be given to any person not listed, including your spouse.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_



PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

**SOCIAL HISTORY**

MARITAL STATUS: ↓ SINGLE ↓ MARRIED ↓ PARTNERED ↓ SEPARATED ↓ DIVORCED ↓ WIDOWED

USE OF ALCOHOL: ↓ NEVER ↓ NO LONGER USE ↓ HISTORY OF ALCOHOL ABUSE

↓ CURRENT USE - TYPE \_\_\_\_\_ ↓ RARE ↓ OCCASIONAL ↓ MODERATE ↓ DAILY

USE OF TOBACCO: ↓ NEVER ↓ QUIT - HOW LONG AGO? \_\_\_\_\_ ↓ SMOKE \_\_\_ PACKS/DAY FOR \_\_\_ YEARS

USE OF RECREATIONAL DRUGS: ↓ NEVER ↓ QUIT - HOW LONG AGO? \_\_\_\_\_ TYPE \_\_\_\_\_

↓ CURRENT USE - TYPE \_\_\_\_\_ ↓ RARE ↓ OCCASIONAL ↓ MODERATE ↓ DAILY

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ↓ 10% ↓ 25% ↓ 50% ↓ 75% ↓ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ↓ CHILDREN-AGE(S) \_\_\_\_\_ ↓ PET(S)-WHAT KIND? \_\_\_\_\_

↓ ELDERLY OR DISABLED FAMILY MEMBER ↓ OTHER \_\_\_\_\_

EXERCISE: ↓ NEVER ↓ RARE ↓ OCCASIONAL ↓ WEEKLY ↓ SEVERAL TIMES A WEEK ↓ DAILY

TYPES OF EXERCISE: \_\_\_\_\_

**FAMILY HISTORY**

DO YOU HAVE A FAMILY HISTORY OF: ↓ DIABETES: TYPE 1 OR TYPE 2 ↓ CANCER ↓ HEART DISEASE

↓ HIGH BLOOD PRESSURE ↓ STROKE ↓ CORONARY ARTERY DISEASE ↓ THYROID DISEASE

↓ RHEUMATOID ARTHRITIS

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

↓ OTHER \_\_\_\_\_

**YOUR MEDICAL HISTORY**

ALLERGIES: ↓ MEDICATIONS \_\_\_\_\_

↓ ANESTHESIA \_\_\_\_\_ ↓ FOODS \_\_\_\_\_

↓ TAPE ↓ LATEX ↓ SHELLFISH ↓ IODINE ↓ OTHER \_\_\_\_\_

↓ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

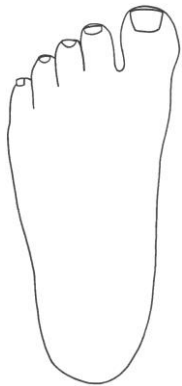
OTHER CONDITIONS:

**CURRENT PROBLEM**

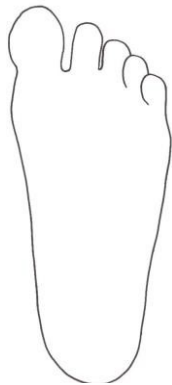
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? \_\_\_\_\_

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

**LEFT FOOT**



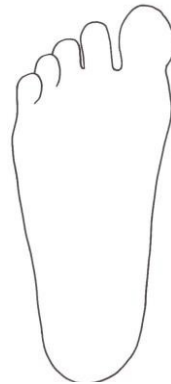
TOP OF FOOT



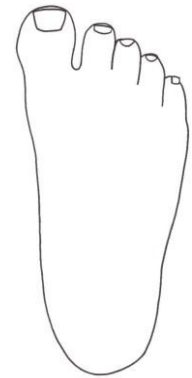
BOTTOM OF FOOT



**RIGHT FOOT**



BOTTOM OF FOOT



TOP OF FOOT



PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

INSIDE OF FOOT

OUTSIDE OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? \_\_\_\_\_ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM:  BEGIN ALL OF A SUDDEN  GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN?  NO PAIN  SHARP  DULL  ACHING  BURNING  
 RADIATING  ITCHING  STABBING  OTHER \_\_\_\_\_

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT:  STAYED THE SAME  BECOME WORSE  IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?  WALKING  STANDING  DAILY ACTIVITIES  
 RESTING  DRESS SHOES  HIGH HEELS  FLAT SHOES  ANY CLOSED TOE SHOE  
 RUNNING  OTHER \_\_\_\_\_

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? \_\_\_\_\_

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? \_\_\_\_\_

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? \_\_\_\_\_

WAS THIS PROBLEM CAUSED BY AN INJURY?  YES (DESCRIBE) \_\_\_\_\_  NO

IF YES, WAS IT A WORK-RELATED INJURY?  YES  NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

\_\_\_\_\_  
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

\_\_\_\_\_  
SIGNATURE OF DOCTOR

\_\_\_\_\_  
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE