4885 DeMoss Rd Ste 103
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BERKS FOOT SPECIALISTS, P.C.

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Medical History/Review of Systems Form

44 S 4th St
Hamburg, Pa. 19526

First Name: _____ **MI:** ____ **Last Name:** _____

Address: _____ **City/State/Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Date of Birth: _____ **Age:** _____ **Sex: M / F** **Height:** _____ **Weight:** _____ **Shoe Size:** _____

Insurance Subscriber/Policy holder name: _____ **Date of Birth** _____

Have you had or ever been treated for:

___ Ankle Sprain
___ Arch Pain
___ Broken Ankle
___ Broken Foot Bones
___ Bunions
___ Childhood foot problems
___ Corns/Calluses
___ Cramps in legs/feet
___ Flat Feet
___ Foot numbness
___ Fungal Nails
___ Hammer/Mallet Toes
___ Gate/Walking Problems
___ Heel Pain
___ Ingrown Nails
___ In-toeing
___ Knee Pain
___ Leg or Foot Ulcers
___ Lower Back Pain
___ Neuroma
___ Rash
___ Toe Walking
___ Warts
___ None of these

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

___ Alzheimer's
___ Anemia
___ Arthritis
___ Asthma
___ Cancer Type: _____
___ Diabetes Type 1
___ Diabetes Type 2
___ Epilepsy
___ GERD
___ Glaucoma
___ Gout
___ Headaches
___ Hearing/Ear Disorder
___ Heart Attack
___ Heart Condition
___ Hepatitis A B C
___ High Blood Pressure
___ Hyperthyroidisms
___ Other_____
___ Hypothyroidisms
___ Keloid Thick Scar
___ Kidney Disease
___ Liver Disease
___ Lung Disease
___ Lyme Disease
___ Nerve Disorder
___ Osteoporosis
___ **Pacemaker/Defibrillator**
___ Phlebitis
___ Poor Circulation
___ Psychiatric Disorder
___ Rheumatic Fever
___ Sciatica
___ Stomach Ulcer
___ Stroke
___ Tuberculosis
___ Vascular Issues
___ None of These

LIST OF PAST SURGERIES:

Type of Surgery	Date

FAMILY HISTORY: (has anyone in your family been treated for)

Arthritis _____ Heart Attack _____
Birth Defects_____ High Blood Pressure _____
Cancer _____ **Type** _____
Diabetes _____ Stroke _____
Foot Problems_____ Other _____
(INDICATE FATHER, MOTHER, SISTER, BROTHER)

ARE YOU A TOBACCO USER/SMOKER:

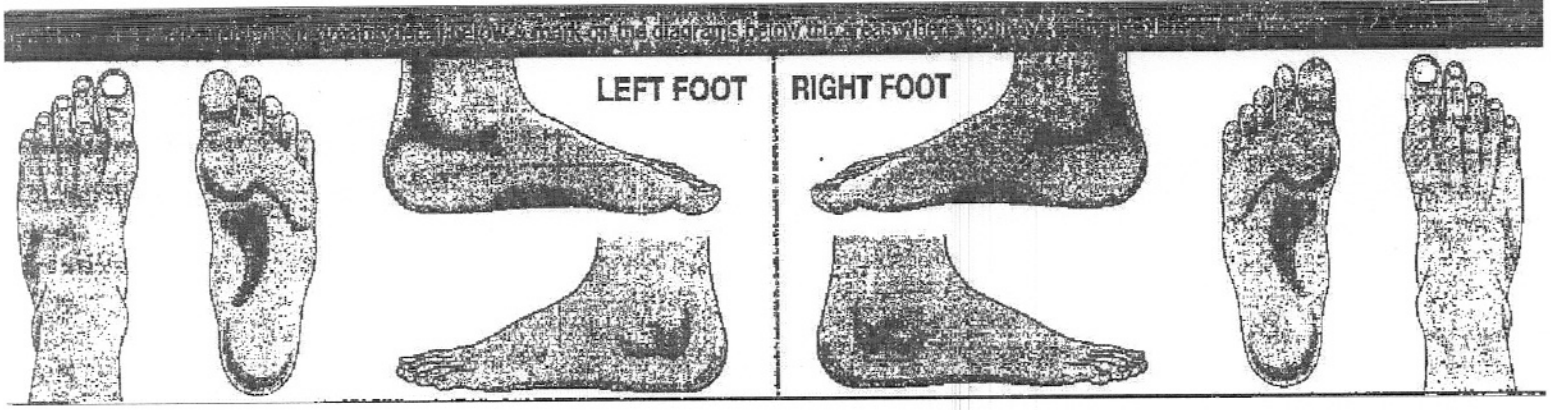
PRESENTLY: _____ **NEVER:** _____

FORMERLY: _____

LIST OF MEDICATIONS:	DOSE:	#PILLS	PER DAY

****

ALLERGIES:	YES / NO	REACTION:
ADHESIVE TAPE	____ / ____	
ADVIL/ALEVE/MOTRIN	____ / ____	
ANTIBIOTICS	____ / ____	
ASPIRIN	____ / ____	
CODEINE	____ / ____	
DEMEROL	____ / ____	
EMPIRIN/TYLENOL	____ / ____	
IODINE	____ / ____	
IV DYE	____ / ____	
LATEX	____ / ____	
MORPHINE	____ / ____	
NOVOCAINE	____ / ____	
OTHER ANESTHETICS	____ / ____	
OTHER NARCOTICS	____ / ____	
PENICILLIN	____ / ____	
SHRIMP	____ / ____	
SULFA DRUGS	____ / ____	
ANY OTHER DRUGS	____ / ____	



PROBLEM #1

Please mark the location of your first problem or pain on diagram above with a number 1.

Describe your problem below and its cause if you know.

_____

_____

_____

Is problem work related? ____ No ____Yes

Date of Injury: _____/_____/_____

Date reported to Employer: _____/_____/_____

How long ago did problem or pain start:

_____Days _____Weeks _____Months _____Years

Type of Pain/Discomfort:

____ Aching Pain
____ Burning Pain
____ Dull Pain
____ Itching
____ Numbness
____ Sharp Pain
____ Shooting Pain
____ Tenderness
____ Throbbing Pain
____ Tingling

Problem Occurs While:

____ Walking
____ Standing
____ None of the Above
____ And/or:

_____

_____

Severity of Pain: (please circle)
0 1 2 3 4 5 6 7 8 9 10
Low >>>>>>>>>>>>> High

PROBLEM #2

Please mark the location of your first problem or pain on diagram above with a number 1.

Describe your problem below and its cause if you know.

_____

_____

_____

Is problem work related? ____ No ____Yes

Date of Injury: _____/_____/_____

Date reported to Employer: _____/_____/_____

How long ago did problem or pain start:

_____Days _____Weeks _____Months _____Years

Type of Pain/Discomfort:

____ Aching Pain
____ Burning Pain
____ Dull Pain
____ Itching
____ Numbness
____ Sharp Pain
____ Shooting Pain
____ Tenderness
____ Throbbing Pain
____ Tingling

Problem Occurs While:

____ Standing
____ Walking
____ None of the Above
____ And/or:

_____

_____

Severity of Pain: (please circle)
0 1 2 3 4 5 6 7 8 9 10
Low >>>>>>>>>>>>> High

Please supply the following information:

Name of Family Physician	Address	Phone	Date Last Seen	Referred to me:
_____	_____	_____	_____/_____/_____	__No __Yes

Name of Practice

_____

Name of Pharmacy	Address	Phone
_____	_____	_____