

PODIATRY HEALTH ASSESSMENT

Dedication. Compassion. Exper	rienos.					
Patient Name:					Foday's Date:	
Patient Address:						
Phone#: Home: _		Cell:				
					Shoe Size:	
					this doctor:	
Is this WORK RE	LATED: Yes	No AUT	O OR PERSONAL	injury:	es No OTHER Injury: Yes No	
If yes to any of th	ne above DES	CRIPTION AND	DATE of injury:		· ·	
					ob 🗆 Stands & Walks at job 🗆 Retired	
	yer:Employer TEL:					
			•			
-	<u></u>				Allergies to Betadine: ☐ Yes ☐ No	
Any problems tal		·	•	i □ INO,	Allergies to betautile. Tes No	
<i>,</i> .		•	•	:n □ Vos □	No Number of veer's	
•		•	do you take insul		· · · · · · · · · · · · · · · · · · ·	
Past major surge	· · · · · · · · · · · · · · · · · · ·					
-	Of The Follo	-	<u>s you have, or ha</u>	ve had:	Chin	
□ Heart □ Circulation		☐ Ast	nma mach ulcers	□ Skin □ Gout		
☐ Frequent Infections		☐ Arthritis		☐ Healing		
□ Kidneys		□ Anemia		□ Neurological Disorder		
□ Lungs		□ Cancer		☐ High Blood Pressure		
□ Hormones		☐ Liver			3	
Do you have a H	eart Valve Im	<i>plant:</i> □ Yes □] No			
<u>Social History:</u>						
Marital Status: [\sqsupset Single	\square Married	\square Divorced	☐ Widov	ved	
Alcohol Use:	\sqsupset Never	\square Rarely	\square Moderate	\square Daily		
Tobacco Use: [\square Yes \square No	# years:	# Packs/Day:		_Do you currently smoke? \square Yes \square No	
Drug Use:	\square Never	Name of Drug	g:		Frequency	
Family History: (Age, Diseases,	If deceased ca	use of death)			
Father:			Mothe	r:		
Children:						
Is there a Family	(blood relativ	ve) history of?				
\square Heart Disease		☐ Arthritis		☐ Bleeding Disorder		
□ Stroke		☐ Bunions			☐ Neurological Disorder	
□ Hammertoes		□ Fla	tfeet	\Box Circulation problems in hands or fe		





Milford Regional



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