

Mid-Michigan Podiatry
Patient Visit Information

Name _____ Date of Birth _____ Today's Date _____

Have you been seen here before: Yes No

Primary Care Physician _____ Date Last Seen _____

Please list up to 3 areas of concern you would like to discuss during your first visit with the doctor.

1. _____

2. _____

3. _____

Have you had any of the following health tests performed within the last year?

Blood work Yes No

MRI of Foot Yes No

Foot X-ray Yes No

CT Scan of Foot Yes No

Ankle X-ray Yes No

Doppler Study Yes No

Vascular Testing Yes No

If yes, what test was performed and where was it performed including blood work. _____

Do you currently wear orthotic? Yes No If yes: How long _____

Are they custom made Yes No If yes, who made them and when were they made _____

Lower Extremity Doppler Y /No. If yes where and when _____

L: Location of the pain or problem (toes, foot, ankle, right, left or both) _____

D: Duration of the pain or problem(days, weeks, months, years) _____

O: Onsset of the pain or problem was it: **SUDDEN or GRADUAL(over time)**

C: Characteristic of the pain or problem pain 1 out of 10 (1 no pain/ 10 worst pain ever) _____

A: Things that Aggravate the pain or problem _____

T: Treatments the patient has tried at home or with another provider: *Have you taken any Nsaids/ Antibiotic/pain meds* _____

Were X-rays performed: R L B/ Foot Ankle Toes Heel When: _____