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HISTORY OF FOOT PROBLEMS

Patient Name:

Date:

1. Onset:

When did the pain start? eg: 1 week, 1 month, 1 year

2. Nature of Pain:

What kind of pain or pains are you having? eg: sharp, dull, shooting, stabbing, aching, radiating, diffuse, constant, intermittent

3. Location:

Where is the pain? eg: right or left foot, toes, top or bottom of foot, arch, heel, ankle, toenails

4. What symptoms do you have? eg: swelling, redness, bruising, burning, itching, numbness, discolored nails, skin flaking, bumps, tiredness, cramping

5. Past Treatment

Self: What have you done to alleviate pain? (rest, ice, medication, change activities, change shoes)

Professional: Have you seen anyone for this problem? What did they do for you? What advice or treatment was given?

6. Footwear

What shoes can you wear? eg: tennis shoes, heels, boots

What shoes do you avoid and why? eg: tennis shoes, boots, heels

7. Work/Recreation

How has this affected your work, if at all?

8. How has this affected your recreational activities? eg: stopped running, skiing, walking, etc

Patient Signature