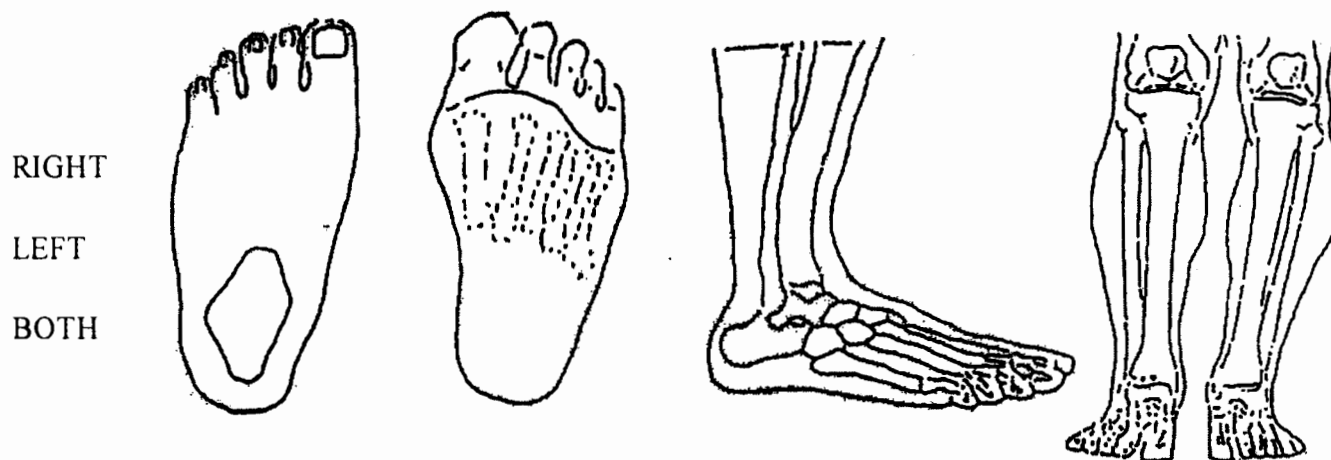


Problem History

Please mark the problem areas on the diagrams below:



Please check the foot or leg problems that apply to you:

- | | | |
|---|--|---|
| <input type="checkbox"/> Ankle/leg/knee pain | <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Unequal leg length |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Heel or arch pain | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> Ingrown toenails | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Corns or calluses | <input type="checkbox"/> Numbness | _____ |
| <input type="checkbox"/> Flat feet | <input type="checkbox"/> Sciatica | |
| <input type="checkbox"/> Foot ulcers or sores | <input type="checkbox"/> Thick, yellow nails | |

Do you have any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Difficulty wearing shoes | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Tingling/pins & needles |
| <input type="checkbox"/> Pain | |

When did your symptoms begin? _____

How did your symptoms begin? _____

What treatments have been tried? _____

Do you spend 50% or more of your time on your feet? Y N

Is the problem getting worse? Y N

Have you stopped exercising or walking due to pain? Y N

Has another doctor treated you for this problem? Y N Who? _____

Name: _____

Date: _____

Age: _____ Shoe Size: _____ Height: _____

Weight: _____