Dr. Margaret L. Meredith, D.P.M.
Total Foot Care of the New River Valley
312 North Main St.
Pearisburg, VA 24134
Phone (540) 553-4300
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Section I: Date:_____

Patient Information

Last Name:_____ MI___ First Name:_____

Preferred Name: _____

Date of Birth: ___/___/_____ Social Security Number: _____-____-_____

Sex: M / F Age:____ Weight_____lbs Height___ft___in Shoe Size____

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Family Doctor:_____ Doctor's Phone Number: (____) ____-_____

Date You Last Saw Your Family Doctor:_____

Please Provide Your Preferred Pharmacy: _____

Employer: _____ Occupation:_____

Race:_____ Religion:_____

Whom May We Thank For Referring You: _____

Contact Information

Address:_____

_____

City:_____ State:_____ Zip:_____

Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____

Email: _____

The Best Time to Contact Me Is: _____ [ ] AM [ ] PM

I Prefer to be contacted on/by [ ] Home Phone [ ] Cell Phone [ ] E-Mail

If you selected your Cell Phone how do you prefer to be contacted [ ] Call [ ] Text

Patient Name:_____ DOB:_____

Emergency Contact

Last Name:_____ MI___ First Name:_____

Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____

Address:_____

_____

City:_____ State:_____ Zip:_____

Responsible Party

Relationship to Patient: [ ] Self [ ] Spouse [ ] Parent [ ] Other
If Self please move to the next section
If Other please specify:_____

Last Name:_____ MI___ First Name:_____

Date of Birth: ___/___/_____ Social Security Number: _____-____-_____

Address:_____

_____

City:_____ State:_____ Zip:_____

Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____

Email: _____

Employer: _____ Occupation: _____

Insurance Information

Who Provides Your Insurance: [ ] Self [ ] Spouse [ ] Parent [ ] Responsible Party
If Self or Same as Responsible Party please move to the next section

Responsible Party:

Last Name:_____ MI___ First Name:_____

Date of Birth: ___/___/_____ Social Security Number: _____-____-_____

Address:_____

_____

City:_____ State:_____ Zip:_____

Employer: _____ Occupation: _____

Patient Name:_____ DOB:_____

Current Problem

Why Are You Being Seen Today? (Describe Your Foot Problem):_____
_____
_____

How Would You Describe Your Pain? (Circle)

Sharp Aching Throbbing Shooting Burning Cramping Numbness Electrical Sensation Pins and Needles

What is The Location of Your Pain? (Circle)

Lower Leg Ankle Achilles Tendon Heel Midfoot Arch Forefoot Sole of Foot Ball of Foot Top of Foot Big Toe Lesser Toes Toenails

How Long has/have your problem(s) been present? (Circle)

1-3 Days 3-7 Days 1-3 Weeks 3-6 Weeks 6-8 Weeks 3-6 Months 6-9 Months 9-12 Months Greater than 1 Year

Onset of condition or injury (Circle)

Gradual onset over time Sudden Onset from Activity or Injury

Course/Progression of condition (Circle)

Severe Worsening Moderate Worsening Mild Worsening Steady/Unchanging Mild Improvement Moderate Improvement Considerable/Good Improvement

Pain/Condition Aggravated By: (Circle)

Any Weight Bearing Standing Walking Running Exercise Bending Stooping

Pressure to Ball of Foot Pressure from Shoes Pressure from Jumping Rubbing from Clothing

Have You Attempted Any Treatments to Relive Your Problem? (Circle)

Rest Ice Elevation Change Shoe Gear Over The Counter Padding In Home Whirlpool

Over The Counter Anti-Inflammatory Medication: (Motrin, Aleve, Tylenol, Aspirin, etc.)

Stretching Trimming Out Toenail Yourself Applying Skin Cream

Applying Topical Antibiotic Ointment: (Triple antibiotic, bacitracin, Neosporin, etc.)

Saw Another Physician for this Problem – (Referred To Us)

Treated for This Condition by Another Physician

Surgery for This Condition by Another Physician

Patient Name:_____ DOB:_____

How Much Improvement and Relief Have You Achieved With Pervious Treatment? (Circle)

Mild Improvement Moderate Improvement Considerable Improvement No Improvement Worsening of Condition

Additional Factors? (Circle)

Pain Worse on 1st Morning Walking/ Activity Pain Worse when Standing

Pain Worse in Shoes Pain Worse with Any Movement Pain Worse after Running/Exercise

Pain Worse after Working on Ladder Pain Decreases after 1st 15-20minutes of Walking

Pain Decreases after Rest Pain Decreases after Removing Shoes

Pain Decreases after Rubbing Area

Pain Decreases after Trimming out Toenails, but returns in several days

What Is Your Activity Level?

Sitting Standing Walking Considerable Movement/Walking

Medical History

Please Circle Any Past Medical Conditions

Hypertension/High Blood Pressure HIV/AIDS Hepatitis Heart Attack/MI Aneurysm Stroke/CVA Insulin Dependent Diabetes Non-Insulin Dependent Diabetes Blood Clot Pre Diabetic

Have You Recently Experienced? (Circle)

Fatigue Nausea Chills Weight Loss Greater than 10lbs Weight Gain Greater than 10lbs

Eyes – Do You Have? (Circle)

Impaired Vision Cataracts Glaucoma Macular Degeneration Frequent Eye Infections

Ears – Do You Have? (Circle)

Hearing Loss Frequent Ear Infections Dizziness Loss of Balance

Nose – Do You Have? (Circle)

Sinus Problems/Allergies Frequent Nose Bleeds Difficulty Breathing Nasal Polyps Deviated Septum

Throat – Do You Have? (Circle)

Frequent Throat Infections Hoarseness Difficulties with Speech Frequent Swollen Nodes/Glands in Neck

Patient Name:_____ DOB:_____

Respiratory – Do You Have? (Circle)

Asthma Bronchitis Emphysema Shortness of Breath Tuberculosis Valley Fever
Lung Cancer Collapsed Lung/Atelectasis Pneumonia

Cardiovascular – Do You Have? (Circle)

Hypertension/High Blood Pressure Myocardial Infarct/Heart Attack Chest Pain Angina
Palpitations/Irregular Beats Valve Prolapse/Heart Murmur Rheumatic Fever Angioplasty
Open Heart/Bypass Surgery Pacemaker Congestive Heart Failure

Vascular/Circulation –Do You Have? (Circle)

Circulation Disorder/Decrease Leg Pain at Rest Leg Pain with Walking High Cholesterol
Phlebitis Atherosclerosis/Blocked Arteries Blood Clot/Deep Vein Thrombosis Varicose Veins

Gastrointestinal – Do You have? (Circle)

Reflux/Heart Burn Ulcer Abdominal Pain Gallbladder Problems Liver Disorder Colitis
Hepatitis A Hepatitis B Hepatitis C Excessive Hunger Excessive Thirst Loss of Appetite

Genitourinary – Do You Have? (Circle)

Frequent Bladder/Urinary Tract Infections Kidney Stone Renal Failure Renal Dialysis
Frequent Urination/Incontinence Ovarian Cancer Prostate Cancer
Prostate Problems/Benign Hyperplasia

Have You Had Any of the Following Sexually Transmitted Diseases? (Circle)

Gonorrhea Syphilis Chlamydia Herpes HIV

Hematological – Do You Have? (Circle)

Anemia Sickle Cell Disease or Trait Cancer/Leukemia Blood Transfusion

Have You Ever Been Anticoagulated with Any of the Following Blood Thinners?

Coumadin (Warfarin) Heparin Aspirin (Acetylsalicylic Acid) Plavix (Clopidogrel)
Other Blood Thinners/Anticoagulants:_____

Endocrine – Do You Have? (Circle)

Diabetes Thyroid Disease

Neurological – Do You Have? (Circle)

Seizures Stroke Tremor Change in Memory Frequent Head Aches Sciatica Numbness
Muscle Weakness Frequent Head Aches Polio Neuro-Muscular Disease

Musculoskeletal - Do You Have? (Circle)

Arthritis/ Degenerative Joint Disease Rheumatoid Arthritis Gout Back Pain Hip Pain
Knee Pain Frequent Muscle/Tendon Pain Fibromyalgia Sciatica

Do You Have Any of The Following Joint Replacements/Prosthesis? (Circle)

Hip Knee Ankle Hands Feet Spine

Date of Joint Replacement(s):_____

Patient Name:_____ DOB:_____

Integument – Do You Have? (Circle)

Skin Rashes Psoriasis Eczema Skin Cancer Hives Skin Growth Thick Scar/Keloid
Itching to Skin Change In Size of Skin Growth Color Change to Mole or Wart

Psychiatric – Do You Have? (Circle)

Depression Nervousness Anxious/OCD Phobias Bipolar Disease Memory Loss
Concentration Difficulties/ADHD Feelings of Worthlessness/Low Self Esteem
Suicidal Thoughts Schizophrenia/Psychosis

Immunology – Do You Have? (Circle)

HIV Frequent Infections/Weak Immune System Chronic Fatigue Syndrome/Epstein Barr

Please List Any Past Injuries or Traumas:

_____
_____
_____
_____

Have You Had Any of the Following Foot Surgeries? (Circle)

Toenail Bunion Hammertoe Fracture Repair Join Fusions Tendon Repair/Rerouting
Ankle Stabilization Arthroscopy Fasciotomy

I Had Surgery For: On Date of: With Complications of:
_____
_____
_____

Have you Had Any of the Following Surgeries? (Circle)

Heart Bypass Heart Valve Repair/Replacement Appendectomy Gallbladder Brain Surgery

I Had Surgery For: On Date of: With Complications of:
_____
_____
_____

Please List Any Other Past Surgeries

I Had Surgery For: On Date of: With Complications of:
_____
_____
_____

Patient Name:_____ DOB:_____

Please List Any Complications/ Problems With Surgery or Anesthetics

_____
_____
_____

Previous Hospitalizations – Have You Been Admitted for? (Circle)

Heart Attack Stroke Pneumonia Cancer Infection Injury

Date of Hospitilazations:_____

Childhood History – Did You Ever Have? (Circle)

Rheumatic Fever Measles Mumps Chickenpox Herpes/Cold Sores

Childhood Immunizations – Have You Been Immunized For? (Circle)

Measles Mumps Rubella Diphtheria Tetanus Varicella Zoster Polio Tuberculosis Pneumonia Flu

Family History

Father – Does/Did Your Father Have?

Cancer Hypertension/High Blood Pressure CVA/Stroke Diabetes Circulation Problems

Any Other Illnesses:_____

Is Your Father Deceased? Yes No

If Your Father Is deceased, what was his age and Cause of Death?

_____

Mother – Does/Did Your Mother Have?

Cancer Hypertension/High Blood Pressure CVA/Stroke Diabetes Circulation Problems

Any Other Illnesses:_____

Is Your Mother Deceased? Yes No

If Your Mother is deceased, what was her age and Cause of Death?

_____

Siblings – Does/Did Your Siblings Have?

Cancer Hypertension/High Blood Pressure CVA/Stroke Diabetes Circulation Problems

Any Other Illnesses:_____

Patient Name:_____ DOB:_____

Social History

Do You? (Circle)

Smoke Tobacco Smoke Marijuana Drink Alcohol Use Cocaine Use Hallucinogenic Drugs Use Other Recreational Drugs

If you use other recreational drugs please list/specify:_____

If you drink. Number of Drinks Per Day? (Circle)

1 2 3 4 5 Greater than 5 per day 1-3/Week 4-6/Week Occasional Use Only Social Drinking Only Weekend Drinking Only

If you smoke. Number of Packs Per Day? (Circle)

½ 1 2 3 4 5 or More 1-2/Week 3-4/Week Occasional Social Weekends

Smoking Status (Circle)

Current Everyday Smoker Current Someday Smoker How Long Have you Smoked_____

Former Smoker for How Long_____ **Never Smoked**

Education (Circle)

Did Not Complete High School Completed High School Some College Completed College Some Grad School Masters Degree Doctorate Degree

Women Only

Are You Pregnant? Yes No

If You Are pregnant, Number of Months:_____ Expected Due Date:_____

Are you currently taking any medications? [ ] Yes [ ] No If yes please list below

Medications: Frequency: For Treatment Of:

_____

_____

_____

_____

_____

If you need more space to list your medications write on the back or ask the receptionist for paper.

Are you currently taking your medications as prescribed [ ] Yes [ ] No

Patient Name:_____ DOB:_____

Do you have any allergies with a history of skin reaction or other outward reaction or sickness following an injection, oral, or topical administration?

Check all that apply	Yes	No	Reaction to Medication
Penicillin	___	___	_____
Other antibiotics (list below)		___	_____
Erythromycin	___	___	_____
Empirin / Tylenol (if yes, Circle)	___	___	_____
Aspirin, Advil, Aleve, or Motrin (Circle)	___	___	_____
Celebrex, Bextra, Vioxx (Circle)	___	___	_____
Other Pain Medicines (list below)	___	___	_____
Morphine	___	___	_____
Codeine	___	___	_____
Demerol	___	___	_____
Other Narcotics (list below)	___	___	_____
Novocaine	___	___	_____
Other anesthetics (list below)	___	___	_____
Sulfa Drugs	___	___	_____
Adhesive tape	___	___	_____
Shrimp, Iodine, or Merthiolate	___	___	_____
Cortisone	___	___	_____
Latex	___	___	_____

Possible Reactions: Mild Moderate Severe Skin Rash Itching Hives GI Upset Nausea Vomiting Diarrhea Wheezing Respiratory Distress Rapid Pulse Heart Palpitations Anaphylaxis

Please list any other Allergies to Medications, Plants, and Food as well as your reactions:

_____
_____
_____
_____

Vitals

What is Your Pulse Rate Per Minute? _____
What is Your Respiratory Rate Per Minute? _____
What is Your Temperature? _____
What is Your Systolic Blood Pressure? (Top Number) _____
What is Your Diastolic Blood Pressure? (Bottom Number) _____
What is your Most Recent Blood Sugar Level? _____

How Did You Hear About Our Office?

(Circle)

Physician Family/Friend Internet Newspaper Phonebook Advertisement totalfootcarenrv.com Other:_____