Doc On the Run - San Francisco Bay Area Podiatry House Calls
236 West Portal Ave., #332, San Francisco, CA 94127
Dr. Christopher Segler, DPM
415.308.0833

Medical History

Name: _____ Today's Date:_____ Age:_____

Date of Birth:_____ Height:_____ Weight:_____ shoe size:_____

How did you hear about us? _____

Chief Complaint

Why are you seeing the doctor today? _____

_____

Most of my pain is in the: (please circle one) **right—left — both.**

Nature of pain: (please circle) **aching—throbbing—sharp—shooting—burning—electrical—radiating**

Location: (circle all that apply) **right—left—both— foot —ankle —leg**

Duration How long have you had this problem? _____**days—months—years**

How many days a week do you have pain? _____days each week.

How many days a week does your pain limit your activities? _____days per week.

Current pain level: (please circle one) (*least* pain) **0 1 2 3 4 5 6 7 8 9 10** (*most* pain)

Onset: (circle all that apply) **came on suddenly—came on gradually—off and on**

Course: (circle all that apply) **getting worse—staying the same—getting better— comes and goes**

Aggravation: My pain is worse when: (please circle one) **I step out of bed— when active— resting—at night.**

What makes it better: _____

Treatment: List any treatment, test, or X-rays you have had for this problem: _____
_____

Current problem is the result of a(n):

____ Car Accident _____ Work Accident _____Other Accident _____NOT Accident Related

_____ _____ _____
Date of Accident Location (Home, School, Work, etc.) Details of Accident or Injury

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Medical History

Past Medical History

Allergies:_____

List all **current medical issues/problems**:_____

_____

_____

Current Medications

Medication	Dose	Times/Day	How Long

Prior Surgeries and Hospitalizations

Surgeries/Hospitalizations	Year	Reason

Have you ever had general anesthesia? _____No _____Yes

Ever had any problems with anesthesia? _____No _____Yes Describe:_____

Any family history of problems with anesthesia? _____No _____Yes Describe:_____

Ever had any problems with Novocain or dentist injections? _____No _____Yes
Describe:_____ _____

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Social History

Employment

_____Employed (occupation _____) _____Work in the home _____Student

Marital Status _____Single _____Married _____Divorced _____Separated_____Widowed

Do you live alone? _____No_____Yes **Children**_____ No _____Yes #_____

Exercise___Daily__Weekly__Monthly__Rarely__Never Type of exercise?_____

Diet: Are you on a special diet? _____ No _____Yes, Describe: _____

Tobacco /Alcohol/ Drugs Usage

Do you smoke currently? _____No _____Yes, _____packs/day for _____ years

Quit smoking? _____This year _____1 yr ago_____ 5 yrs ago ____10 or more yrs ago

(Previously smoked _____packs/day for _____ years)

Alcohol? _____Daily_____1-2x/week____1-2x/month _____1-2x/year

History of substance abuse? _____No _____Yes, What? _____

Family History

Do any of your family members have a history of the following:

Diagnosis	Circle		Relationship to you:
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Rheumatologic disorder	No	Yes	_____
Heart Disease	No	Yes	_____
Stroke	No	Yes	_____
Bleeding Disorders	No	Yes	_____
Kidney Disease	No	Yes	_____
Mental Illness	No	Yes	_____
Cancer	No	Yes	_____

Review of Systems

Are you currently having or have you had problems with: **(Please circle all that apply)**

General/Constitutional: nausea—chills—vomiting—fever—night sweats—weakness— **NONE**
Eyes/Ears/Nose/Throat: glasses/cataracts—hard of hearing—sinuses—difficulty swallowing **NONE**
Lungs: COPD—asthma—shortness of breath—cough—TB—cannot sleep lying flat — **NONE**
Heart: chest pain—heart disease—heart attack—stent/bypass surgery— high blood pressure **NONE**
Gastrointestinal: stomach ulcers——reflux disease—colitis—constipation—upset stomach **NONE**
Genitourinary: bladder problems——prostate problems—urinary tract infection— incontinence **NONE**
Endocrine: diabetes——thyroid problems—liver trouble—kidney trouble—dialysis **NONE**
Hematological Cancer ——Bleeding problems——blood thinners **NONE**
Vascular: swelling in feet/legs/ankles — circulation problems to feet— high blood pressure **NONE**
Neurological: numbness—tingling—electrical /shooting pains in feet/ankles/legs— seizures **NONE**
Dermatological: infection—open wound—redness——ingrown toenail —painful toenails— bruising— bleeding—warts—calluses—cracking heels—dry/peeling skin —sweaty feet—athlete's foot— **NONE**
Musculoskeletal: heel or arch pain—ball of foot pain—top of foot pain—pain/fatigue of feet/legs/ankle —weak or unstable ankles—Achilles tendon pain—difficulty with brisk walking or running— arthritis **NONE**
Description:

_____
_____
_____