Dr. Sherry Lu
Podiatrist
13425 Hoover Creek Blvd, #201
Charlotte, NC 28273

COMPREHENSIVE HEALTH REVIEW

Patient Name: _____ Date of Birth: _____ Today's Date: _____

MEDICATIONS (Include RX meds, OTC meds, and vitamins)

Medication	Dosage	Medication	Dosage
1._____	_____	6._____	_____
2._____	_____	7._____	_____
3._____	_____	8._____	_____
4._____	_____	9._____	_____
5._____	_____	10._____	_____

ALLERGIES

☐ None ☐ Latex
☐ Adhesives/Tape ☐ Local Anesthetics
☐ Aspirin ☐ Penicillin
☐ Codeine ☐ Seafood/Shellfish
☐ Iodine ☐ Sulfa Drugs
☐ Cortisone ☐ _____

SOCIAL HISTORY

Occupation: _____ I Stand _____ % of My Day

☐ I Drink Alcoholic Beverages How much/often? _____ I Exercise Each Week: ☐ 0 Days ☐ 1-2 Days ☐ 3+ Days

☐ I Use or Have Used Tobacco Products Type: _____ List Sports/Activities: _____

Packs/Day _____ Years _____ When Stopped? _____ _____

☐ I Use or Have Used Drugs that are Illegal _____ ☐ My foot/ankle problem limits my activities

I Live With: ☐ No One ☐ Spouse ☐ Children ☐Parents ☐ Other I am: ☐ Single ☐Married ☐Divorced ☐ Sep. ☐ Widowed

REVIEW OF SYSTEMS

CONSTITUTIONAL
☐ Recent Weight Changes
☐ Fever/Chills
☐ Nausea or Vomiting
☐ Fatigue

EYES
☐ Eye Disease/Injury
☐ Wear Glasses/Contacts
☐ Blurred or Double Vision
☐ Glaucoma

EARS/NOSE/MOUTH/THROAT
☐ Hearing Loss
☐ Nose Bleeds
☐ Sore Throat/Voice Change
☐ Sinus Problems
☐ Difficulty Swallowing

CARDIOVASCULAR
☐ Chest Pain
☐ Palpitations
☐ Arrhythmia/Irregular Heart Beat
☐ Leg Pain when Walking
☐ Swelling of Hands/Feet

MUSCULOSKELETAL
☐ Muscle Pain or Cramps
☐ Joint Pain
☐ Stiffness/Swelling Joints
☐ Low Back Pain
☐ Trouble Walking

GASTRONINTESTINAL
☐ Indigestion/Heartburn
☐ Diarrhea
☐ Blood in Stools
☐ Stomach Pains

RESPIRATORY
☐ Shortness of Breath
☐ Chronic/Frequent Cough
☐ Wheezing

GENITOURINARY
☐ Frequent Urination
☐ Painful Urination
☐ Kidney Stones
☐ Blood in Urine

INTEGUMENTARY
☐ Rash or Itching
☐ Dry Skin
☐ Change in Hair/Nails

HEMATOLOGICAL
☐ Bruise Easily
☐ Slow to Heal

ENDOCRINE
☐ Hormonal Problem
☐ Excessive Thirst
☐ Excessive Urination
☐ Too Hot/Too cold

NEUROLOGICAL
☐ Migraines
☐ Frequent Headaches
☐ Numbness/Tingling
☐ Dizzy Spells
☐ Paralysis/Tremors

PSYCHIATRIC
☐ Anxiety
☐ Depression
☐ Nervousness
☐ Insomnia
☐ Confusion/Memory Loss

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Patient Name: _____ Date of Birth: _____ Today's Date: _____

STATS

Age _____ Height_____ Weight_____ Shoe Size _____

For Office Staff

BP_____ P _____ Wt ____ lbs BMI_____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

_____

_____

When did the problem begin? _____

The problem is: ☐ Improving ☐ Worsening ☐ Unchanged

What aggravates the problem? _____

Is the problem painful? ☐ Yes ☐ No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Cramping ☐ Itching ☐ Popping
☐ Burning ☐ Tingling ☐ Clicking ☐ Shooting ☐ Stabbing ☐ Other _____

Which foot/ankle is involved? ☐ Right ☐ Left ☐ Both

First visit to a doctor for this problem? ☐ Yes ☐ No

Have you had a similar problem in the past? ☐ Yes ☐No

How was the problem onset? ☐ Sudden ☐ Gradual

The problem is worst: ☐ AM ☐ PM ☐ At Rest ☐ W/Activity

What improves the problem? _____

Describe previous treatments: _____

Is this from an Injury? ☐ Yes ☐ No If so, is it work-related? ☐ Yes ☐ No _____

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PAST MEDICAL HISTORY

☐ Diabetes Type 1 2 Duration ____ years Last Blood Sugar ____ HbA1c_____
☐ Acid Reflux
☐ Anemia
☐ Anesthesia Complications
☐ Arthritis (☐ Osteo /☐ Rheum)
☐ Asthma
☐ Back Problems / Sciatica
☐ Blood Clot/ DVT
☐ Cancer: _____
☐ Cellulitis/Skin Infection (☐MRSA)
☐ Circulation Problem
☐ Dementia / Alzheimer's
☐ Excessive / Easy Bleeding
☐ Fibromyalgia
☐ Foot/ Leg Ulcer
☐ Gout
☐ Healing Problems / Keloids
☐ Heart Disease / Heart Attack
☐ High Blood Pressure (☐ Low BP?)
☐ High Cholesterol
☐ Hormone Therapy
☐ Immune Disorder / HIV
☐ Kidney Disease (☐ Dialysis)
☐ Liver Disease (☐ Hepatitis)
☐ Leg Cramps/Leg Pain at Rest
☐ Lung Condition: _____
☐ Mitral Valve Prolapse/Murmur
☐ Multiple Sclerosis
☐ Nervous Disorder / Depression
☐ Neuropathy
☐ Osteomyelitis/Bone Infection
☐ Parkinson's Disease
☐ Previous Addiction to: _____
☐ Pulmonary Embolism
☐ Rashes/Skin Condition
☐ Raynauds Disease/Phenomena
☐ Seizure Disorder/Epilepsy
☐ Sickle Cell Disease/Trait
☐ Sleep Apnea
☐ Stomach Ulcers
☐ Stroke ☐ Rt ☐ Lt (year_____)
☐ Thyroid Condition (☐ Hi ☐ Low)
☐ Varicose Veins
☐ Women- Are you pregnant or breastfeeding? ☐ Yes ☐ No
_____
☐ Other problems not listed: _____

PAST SURGERIES

☐ Foot/Ankle Surgery: _____
☐ Joint Replacement: _____
☐ Open Heart/Bypass Surgery
☐ Hysterectomy ☐ Tubal Ligation ☐ C- Section
☐ Stent Placement: ☐ Heart ☐ Leg
☐ Cosmetic Surgery: _____
☐ Appendix ☐ Gallbladder ☐ tonsils/Add
☐ Leg Bypass ☐ Open Fracture Repair
☐ Carotid Surgery ☐ Vein Surgery
☐ Hernia Repair ☐ Thyroid ☐ Back Surgery
☐ Other: _____

FAMILY HISTORY (CIRCLE RELATIVE)

☐ Cancer M F S B GP
☐ Diabetes M F S B GP
☐ Gout M F S B GP
☐ Heart Disease M F S B GP
☐ High Blood Pressure M F S B GP
☐ Severe Arthritis M F S B GP
☐ Anesthesia Complications M F S B GP
☐ Foot Problems M F S B GP
☐ Other: _____

I understand that completing this paperwork is a chore. The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care.

X _____ _____

PATIENT/GUARDIAN SIGNATURE DATE