



**MT. AIRY FOOT & ANKLE CENTER**  
**DR. JAMES R. SHIPLEY, DPM**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ALL PRIOR SURGERIES/HOSPITALIZATIONS (INCLUDE APPROXIMATE DATE):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

USE OF ALCOHOL:  NEVER  NO LONGER USE  HISTORY OF ALCOHOL ABUSE  
 CURRENT USE - TYPE \_\_\_\_\_  RARE  OCCASIONAL  MODERATE  DAILY

USE OF TOBACCO:  NEVER  QUIT - HOW LONG AGO? \_\_\_\_\_  SMOKE \_\_\_\_\_ PACKS/DAY FOR \_\_\_\_\_ YEARS

USE OF RECREATIONAL DRUGS:  NEVER  QUIT - HOW LONG AGO? \_\_\_\_\_ TYPE \_\_\_\_\_  
 CURRENT USE - TYPE \_\_\_\_\_  RARE  OCCASIONAL  MODERATE  DAILY

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

**FAMILY HISTORY**

DO YOU HAVE A FAMILY HISTORY OF:  DIABETES  CANCER  HEART DISEASE  HIGH BLOOD PRESSURE  
 STROKE  CORONARY ARTERY DISEASE  THYROID DISEASE  RHEUMATOID ARTHRITIS  
 OTHER \_\_\_\_\_

**YOUR MEDICAL HISTORY**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SHOE SIZE \_\_\_\_\_

HAVE YOU EVER BEEN TESTED POSITIVE FOR: (CIRCLE) TB, HEPATITS, HIV/AIDS, MRSA, OTHER \_\_\_\_\_

ALLERGIES:  NONE KNOWN  MEDICATIONS \_\_\_\_\_  
 ANESTHESIA \_\_\_\_\_  FOODS \_\_\_\_\_  
 TAPE  LATEX  SHELLFISH  IODINE  OTHER \_\_\_\_\_

DO YOU HAVE ANY KNOWN MEDICAL CONDITIONS CONCERNING:

\_\_\_\_ EYES                      \_\_\_\_ CHEST                      \_\_\_\_ STOMACH                      \_\_\_\_ MUSCLES  
\_\_\_\_ EARS                      \_\_\_\_ HEART                      \_\_\_\_ INTESTINES                      \_\_\_\_ BONES  
\_\_\_\_ NOSE                      \_\_\_\_ LUNGS                      \_\_\_\_ LIVER  
\_\_\_\_ THROAT                      \_\_\_\_ KIDNEYS

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HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE Y OR N)

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

IF YOU ARE DIABETIC, DO YOU TAKE INSULIN? \_\_\_\_\_ LAST GLUCOSE READING \_\_\_\_\_

**CURRENT PROBLEM**

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? \_\_\_\_\_

HOW LONG AGO DID THIS PROBLEM FIRST START? \_\_\_\_\_ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM:  BEGIN ALL OF A SUDDEN  GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN?  NO PAIN  SHARP  DULL  ACHING  BURNING  
 RADIATING  ITCHING  STABBING  OTHER \_\_\_\_\_

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)  
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT:  STAYED THE SAME  BECOME WORSE  IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?  WALKING  STANDING  DAILY ACTIVITIES  
 RESTING  DRESS SHOES  HIGH HEELS  FLAT SHOES  ANY CLOSED TOE SHOE  
 RUNNING  OTHER \_\_\_\_\_

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? \_\_\_\_\_

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? \_\_\_\_\_

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? \_\_\_\_\_

WAS THIS PROBLEM CAUSED BY AN INJURY?  YES (DESCRIBE) \_\_\_\_\_  NO