Simon Donets, DPM
Yelana Barsky, DPM

GlobalPodiatry
Trust Your Feet in Our Hands

Name: _____ Contact Telephone#: _____

Height: _____ Weight: _____ Age: _____ Sex: _____ Shoe size: _____

What Brings You to Our Office: _____

DIABETES SCREENING: Do you have Diabetes? **Y N** Diabetes in Family: **Y N** WHO? _____

Last Fasting Blood Sugar (eg. this morning): _____ Last HGBA1c (3month evaluation): _____

Do you have ☐pain, ☐numbness, ☐burning, ☐tingling, ☐loss of feeling in you feet or legs (mark check box)

Explain: _____

VASCULAR SCREENING: Have you been tested for lower extremity circulation? Y N When:?_____

Do your legs hurt when walking? **Y N** How long can you walk before needing to rest?_____

Do your feet feel cold at bedtime? **Y N** Do you use a "blood thinner"? **Y N (list below)**

Do you have high blood pressure? **Y N** Do you bruise easily: **Y N** Do you have low back pain: **Y N**

Do you use nicotine products? **Y N** How much? _____ How many years? _____

Do you drink? **Y N** How much? _____ Other drugs? **Y N**

Past LOWER EXTREMITY Surgery (HIP, KNEE, ANKLE, FOOT): _____

_____

Hospitalization (recent 10 years): _____

LIST OF MEDICATIONS: _____

_____

ALLERGIES?: _____Do you have any implants: **Y N**

FAMILY HISTORY/ ROS: Patient Family Please Explain Each **Yes** Answer

Heart Trouble	☐	☐	**Y N**
High Blood Pressure	☐	☐	**Y N**
Kidney Problems	☐	☐	**Y N**
Lung Problems	☐	☐	**Y N**
Asthma	☐	☐	**Y N**
Stomach/Bowel	☐	☐	**Y N**
Liver Problems	☐	☐	**Y N**
Epilepsy/Seizures	☐	☐	**Y N**
Arthritis	☐	☐	**Y N**
Cancer	☐	☐	**Y N**
Venereal Disease	☐	☐	**Y N**
Skin/nail (psoriasis, fungus)	☐	☐	**Y N**
Other	☐	☐	**Y N**

Comments:

DATE: _____ SIGNED: _____