**DR. THONG VAN TRUONG, DPM, INC**
**MEDICAL INFORMATION**

1. How is your general health? Poor_____ Fair_____ Good_____ Excellent_____

2. Are you now under a doctor's care? Yes_____ No_____ Doctors Name:_____

   Reason:_____

3. Medications you are taking:_____

   _____

4. What currently bothers you about your feet?_____

5. Location on the foot: RIGHT or LEFT: toes - ingrown nail - ball of foot - heel - arch - ankle (circle one) Other:_____

6. History of injury (if any):_____

7. Type of pain - circle all that apply: soreness - pinching - stinging - stabbing - throbbing - shooting - numbness - tingling - burning - dull pain Other:_____

8. Rate your pain on a scale of one to ten - ten being most painful: 1 2 3 4 5 6 7 8 9 10 +

9. What makes the pain worse? _____

10. How long has this bothered you? _____

11. Have you had any surgeries in the last 5 years? What and when:_____

12. Have you been to a podiatrist before? Yes_____ No_____ Doctors Name:_____

    If yes, what was the past treatment? _____

13. Have you or are you being treated for the following:

| | | |
|---|---|---|
| Diabetes Y or N | Difficulty in healing Y or N | Rheumatic Fever Y or N |
| Ulcers Y or N | Kidney problems Y or N | Tuberculosis Y or N |
| Anemia Y or N | Liver problems Y or N | Heart problems Y or N |
| Gout Y or N | High blood pressure Y or N | Shortness of breath Y or N |
| Epilepsy Y or N | Other:_____ | |

14. Do you have any allergies to any medications? If yes, please list:_____

    _____

PRINTED NAME:_____DATE:_____