



Dr. Scot F. Bertolo, DPM
 4485 N. High Street
 Columbus, Ohio 43214
 Office: (614) 824-5336
 Fax: (614) 732-4990
 www.UrbanPodiatry.com

Patient Information _____ Today's Date: ___/___/___
 (To be completed **fully** by the patient or guardian—leave **no** section incomplete)

Patient name: _____ Date of Birth: ___/___/___ Age: _____

Height: _____ Weight: _____ Shoe Size: _____ Shoes: _____ (work)
 _____ (home)
 _____ (leisure)

Reason for Today's Visit: (Chief Complaint—please be specific)

- 1.) _____
- 2.) _____
- 3.) _____

History of Present Illness: (Describe your complaint—please be specific)

Location on foot/ankle/leg: _____

Duration: ___ (day / week / month / year) Onset:(Sudden / Gradual) Painful?: Y / N Pain rating ___/10

Aggravating Factors: _____

Treatment to Date: _____

Past Medical History: (Circle all that apply)

Endocrine: Diabetes (Type I or II) Thyroid Disease (Hypo/Hyper) Osteoporosis Obesity

Cardiovascular: High Blood Pressure High Cholesterol Heart Disease Heart Attack Anemia

Congestive Heart Failure Prolapsed Valve Bleeding Disorder Sickle Cell

Peripheral Vascular Disease Venous Insufficiency DVT Raynauds

Pulmonary: Smoker Asthma COPD Tuberculosis Pulmonary Embolism Sleep Apnea

Gastrointestinal: Stomach Ulcer Reflux Liver Disease/Hepatitis Diverticulitis Crohns Disease

Ulcerative Colitis Irritable Bowel Syndrome Hernia Gall Stones

Renal/Kidney: Stones Insufficiency Failure Dialysis

Musculoskeletal: Osteo Arthritis (back/hip/knee/foot/hands) Lower Back Problems Gout

Rheumatoid Arthritis Psoriatic Arthritis Reiters Arthritis

Foot Deformity (Type? _____ Surgery? _____)

Psych/Neuro: Seizure Disorder Paresthesias(numbness/tingling) Stroke-(Right or Left side deficits)

Neuromuscular Disease (CMT/MS/MD/ALS) Parkinsons Disease Alzheimers Dementia

Integument/Skin: Athletes Feet Fungal Toenails Callused Skin Dry Skin Warts Ulcers

Cellulitis Easy Bruising Dermatitis Dermatitis Eczema Psoriasis Chronic Rash

Other: Cancer (Type, When, Treatment _____)

HIV/AIDS Vision Problems (Cataracs/Glaucoma/Macular Degen./Blind) Deaf Mute



Dr. Scot F. Bertolo, DPM
4485 N. High Street
Columbus, Ohio 43214
Office: (614) 824-5336
Fax: (614) 732-4990
www.UrbanPodiatry.com

Past Surgical History: (list any & all surgeries & hospitalizations)

- 1.) _____ Date: _____
- 2.) _____ Date: _____
- 3.) _____ Date: _____
- 4.) _____ Date: _____
- 5.) _____ Date: _____

Medications: (list any & all medications including vitamins/supplements)

- 1.) _____ 8.) _____
- 2.) _____ 9.) _____
- 3.) _____ 10.) _____
- 4.) _____ 11.) _____
- 5.) _____ 12.) _____
- 6.) _____ 13.) _____
- 7.) _____ 14.) _____

Allergies: (list all drug allergies or intolerances) _____ KKDA (no know drug allergies)

- 1.) _____ Reaction: _____
- 2.) _____ Reaction: _____
- 3.) _____ Reaction: _____
- 4.) _____ Reaction: _____
- 5.) _____ Reaction: _____

Social History: (please check or circle the appropriate answer)

Marital Status: Single___ Married/Life Partner___ Separated/Divorced___ Widowed___
Children: Son(s)___ Daughter(s)___ *Live alone:* Y N (if no then with whom___)
Living arrangements: House Apartment Nursing Home Shelter Homeless
Occupation: _____ Retired: Y N
Employer: _____
Disabled: Partial Disability__ Full Disability__ Reason For Disability_____
Alcohol Use: Never___ Rare___ Moderate___ History of abuse___ Recovering___
Tobacco Use: Nonsmoker___ Cigarettes___ (___#packs/day___#years) Cigar/Pipe___
 Chew___ Second Hand Smoke ___
Illicit/Recreational Drug Use: Never __ Occasional __ History of abuse & Type _____

Family History: (circle any conditions that exist in **YOUR** immediate family)

Diabetes Heart Disease High Blood Pressure High Cholesterol/Lipids Stroke Arthritis
 Neurologic Disease Asthma/Lung Disease Mental Illness Thyroid Disease
 Cancer (Type-Please Describe): _____
 Other (Please Describe): _____