VARNI FOOT & ANKLE CARE

2851 Joe DiMaggio Blvd #8
Round Rock, TX 78665
P: 512-843-0770
F: 512-843-0648

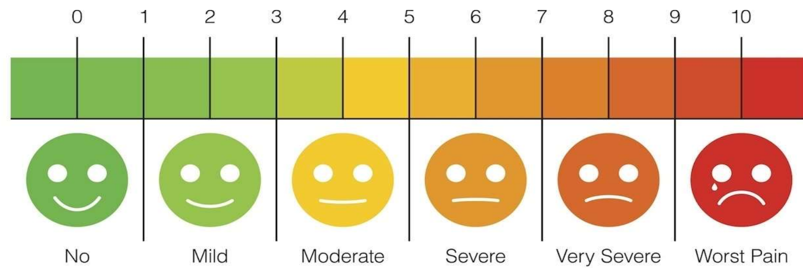
Current Problem:

What brings you in today? ____

Duration/ Onset: ___________________________ Injury: ☐ Yes ☐ No

Previous Treatment(s): ____

Pain Scale (Circle one):



Current Weight: _______ lbs. Height: ____ft. ____ in. Shoe Size: ___________

Medical History

Select all that apply

Alzheimer's	COPD	Kidney Disease
Anxiety/ Depression	Dementia	Migraines/ Headaches
Arthritis	Diabetes Type 1 or 2	Multiple Sclerosis
Asthma	Fibromyalgia	Neuropathy
Autoimmune Disorders	GERD	Osteoporosis
Back Trouble	Gout	Rheumatoid
Bleeding Disorder	Heart Attack	Sickle Cell Disease
Blindness	Heart Disease	Stomach Ulcers
Blood Clots/ DVT	Hepatitis	Stroke
Bronchitis/ Emphysema	High Blood Pressure	Thyroid Disease
Cancer: Type__________________	High Cholesterol	Use of Steroids past 6 months
Chronic Pain	HIV/AIDS	Valvular Dysfunction

Other: ____

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Allergies

Select all that apply

Penicillin Latex Sulfa Codeine Gluten Shellfish

Other: ____

Surgical History

Please indicate year

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Social History

Current Occupation: ____

Marital Status: ☐Single ☐Married ☐Widow ☐Divorced ☐Other ____________________

Smoking: ☐ Never ☐Former: ____ Years; Quit Year: ____ ☐Active: Start Year: _____ Quantity: ____

Alcohol: ☐Never ☐Once a week ☐2-3 Times a week ☐Greater than 3 Times a week

Family History

Medical Conditions/Relationship: ____

____

Medications

Please indicate name and dosage. You may provide a separate list, if available

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

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Hospitalizations

Please indicate medical condition and year

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

Review of Systems

(Circle all that apply)

System	Symptoms
General	Fever Chills Weight Loss Weight Gain Fatigue
Eyes	Blurry vision Visual disturbances Headaches
Ears, Nose, Throat	Ringing Hearing Problems Difficulty Swallowing Sore Throat
Cardiovascular	Chest Pain Palpitations Leg Swelling
Respiratory	Wheezing Shortness of Breath Cough
Gastrointestinal	Heartburn Abdominal Pain Diarrhea Constipation Nausea Vomitting
Urinary	Painful Urination Bladder Leakage
Musculoskeletal	Joint Pain Swelling Stiffness Back Pain Arthritis Muscle Weakness
Skin	Rash Lesions Itching Redness Wounds Dryness
Neurological	Numbness of hands/feet Seizures Tremors Paralysis Dizziness
Psychiatric	Depression Anxiety Trouble Sleeping Memory Loss
Hematology	Easy bruising Abnormal bruising

Other ongoing issues: ____