UTOEPIA
FOOT AND ANKLE SPECIALIST

Christian Smith, DPM, FACFAS
452 Perkins Extended
Memphis TN 38117
p 901-730-8300 f 9017308111
utoepia8637@gmail.com
utoepia.com

Podiatry Medical History Form

Patient Information

Full Name:_____

Date of Birth:_____

Phone Number/Best Contact Number:_____ Is it “ok” to text? Yes___ No____

Email:_____

Home Address:_____

City_____ State_____ Zip Code_____

Emergency Contact Name & Phone:

Name_____ Phone Number_____

Primary Complaint

What brings you in today? (e.g., heel pain, bunions, ingrown toenails, etc.):

How long has this issue been present?

Have you had any previous treatments for this condition? (Yes/No)

If yes, please specify:

Medical History

[ ] Diabetes
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Heart Disease
[ ] Peripheral Neuropathy
[ ] Peripheral Arterial Disease (PAD)
[ ] Stroke
[ ] Osteoarthritis
[ ] Rheumatoid Arthritis
[ ] Gout
[ ] Cancer
[ ] Blood Clots / DVT
[ ] Other (please specify):

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Foot & Ankle History

Any history of foot or ankle surgeries? (Yes/No)
If yes, please explain:

Any history of fractures, sprains, or injuries to feet or ankles? (Yes/No)
Do you experience:
[ ] Numbness
[ ] Tingling
[ ] Burning sensations
[ ] Swelling
[ ] Pain with walking/standing
[ ] Open sores or wounds
[ ] Toenail problems (fungus, ingrown nails)
[ ] Skin conditions (corns, calluses, warts)

Medications

Please list all current medications (including over-the-counter, vitamins, supplements):

Allergies

Do you have any medication or material allergies? (e.g., latex, adhesive):

Lifestyle & Habits

Do you smoke? [ ] Yes [ ] No
[ ] Former smoker
Alcohol consumption: [ ] None [ ] Occasionally [ ] Frequently
Activity Level: [ ] Sedentary [ ] Lightly Active [ ] Active [ ] Very Active
Type of footwear most often worn:
Occupation:

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Family Medical History

Any family history of foot problems, diabetes, or circulatory issues? (Yes/No) If yes, please specify:

Insurance Information

Primary Insurance:_____

Policy Number:_____

Group Number:_____

Subscriber Name:_____

If primary policy holder is someone other than yourself:

Name_____ Date of Birth_____

Secondary Insurance:

Policy Number:_____

Group Number:_____

Subscriber Name:_____

If the primary policy holder is someone other than yourself:

Name_____ Date of Birth_____

Signature_____ Date:_____