MILLER
ORTHOPEDIC
SPECIALISTS

PODIATRIC MEDICAL INFORMATION

(Please Complete In Full)

Patient's Name _____

Foot Problem and/or Symptoms _____

_____

_____

_____

How Long Have You Had This Problem (please fill in a number)?

_____ Days _____ Weeks _____ Months _____ Years

PLEASE MARK WITH AN "X" WHERE YOUR PAIN IS LOCATED: