



MILLER
ORTHOPEDIC
SPECIALISTS

PODIATRIC MEDICAL INFORMATION

(Please Complete In Full)

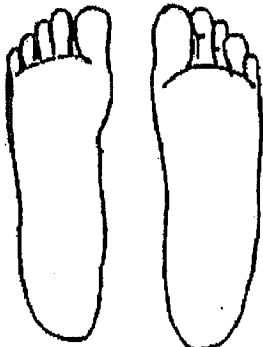
Patient's Name _____

Foot Problem and/or Symptoms _____

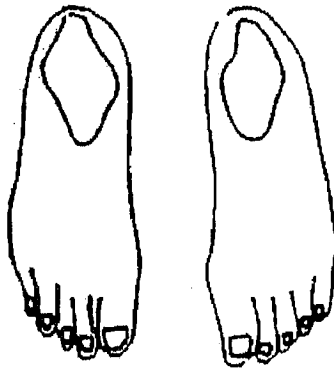
How Long Have You Had This Problem (please fill in a number)?

_____ Days _____ Weeks _____ Months _____ Years

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



R L
Bottom View



R L
Top View



L
Inside Foot



L
Outside Foot



R
Inside Foot



R
Outside Foot



L
Back of Leg



R
Front of Leg



L
Front of Leg



R
Back of Leg