



MILLER  
ORTHOPEDIC  
SPECIALISTS

# PODIATRIC MEDICAL INFORMATION

(Please Complete In Full)

Patient's Name \_\_\_\_\_

Foot Problem and/or Symptoms \_\_\_\_\_

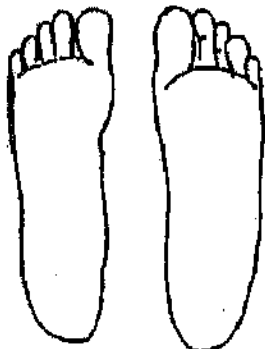
\_\_\_\_\_

\_\_\_\_\_

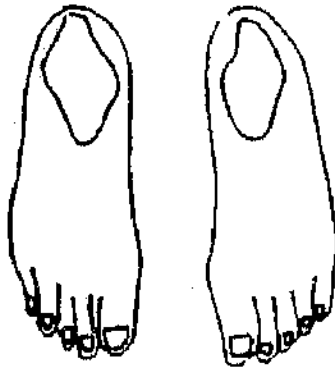
How Long Have You Had This Problem (please fill in a number)?

\_\_\_\_\_ 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