# PAUL V. SPIEGL, MD

**DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY**
**5671 PEACHTREE DUNWOODY ROAD, SUITE 750**
**ATLANTA, GEORGIA 30342**
**PHONE: (404) 255-5595**
**FAX: (404) 252-2780**


## PATIENT MEDICAL HISTORY REQUEST

Patient Name:________________________________________Patient Age:__________

Length of time suffering from the onset of _____________ months or years (circle one)

___Chronic Proximal Plantar Fascitis
___Chronic Lateral Epicondylitis

Other Dx____________________________________________________________

I have tried the following conservative treatments without relief: (check all that apply)

__Cortisone Injections __Physical Therapy __Stretching
__Foot Supports (Orthotics) __Night Splints __NSAIDS
__Changes in foot gear __Other_________________________________________

Please provide a medical history of your condition with how it affects your personal life and your work, i.e. can no longer exercise, unable to stand for long periods of time and job requires standing. Please list all types of treatments, medication, or devices, prescribed and not prescribed, that you have tried for your condition. Please try to include dates. Have any of the treatments helped with your symptoms in any way?

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Signature of Patient Date