

MEDICAL HISTORY

Family physician _____ Date of last physical _____

Please describe your foot problem _____

Have you had any previous foot care or foot surgery? _____

Have you been treated for any foot problems in last 90 days by podiatrist or another physician? Yes No

GENERAL HEALTH

Height _____ Weight _____ Age _____ Shoe Size _____

Last Blood Sugar _____ Last Blood Pressure Reading _____

Are you under a doctor's care at the present time? Yes _____ No _____

How often do you use Alcohol? _____ Nicotine? _____

(Please check any of the following for which you have been or are being treated)

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Glaucoma/Eye | <input type="checkbox"/> Cardiac Disease |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Peripheral Vascular Disease
circulation | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hemophilia (Bleeder) | <input type="checkbox"/> Gastro Intestinal
Disorders |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Renal Disease (kidney) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Polio, Cerebral Palsy,
Muscular Dystrophy | <input type="checkbox"/> Cerebral Accidents (Stroke) | <input type="checkbox"/> Phlebitis/Thrombo |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver Disease (Hepatitis) |
| <input type="checkbox"/> Thyroid (Hypo of Hyper) | <input type="checkbox"/> Other - Please State | |

Women: Are you pregnant? _____ Due Date _____

ALLERGIES: Are you allergic to any of the below? - Please check.

- | | | | | |
|--|--|------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Novacaine |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Iodine Dyes | <input type="checkbox"/> Foods |
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Environmental | <input type="checkbox"/> Caffeine | <input type="checkbox"/> Other | |

Are you taking any medications Yes or No if yes, please list
(Please include Vitamins or Birth control Pills)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Have you had any previous surgery or hospitalization? (Include Fractures/Dislocations)

Yes ___ No ___ Please List _____

