

MEDICAL HISTORY

IMPORTANT FIRST VISIT MEDICAL INFORMATION – PLEASE FILL THIS OUT AS COMPLETELY AS POSSIBLE IN ORDER FOR US TO GIVE YOU THE BEST POSSIBLE CARE!

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Shoe Size: _____

Briefly describe your Problem: _____

Which Foot? Right Left Both - How long has this been a problem? _____

What started it or makes it worse? _____

What makes it feel better? _____

What treatment have your had? _____

List all Allergies or Adverse reactions to medications or other medical products: _____

List ALL medicines you take, the dosage and reason for taking: _____

List ALL surgeries and hospitalizations-not just feet: _____

List all previous significant INJURIES and approximate dates (Broken bones, sprains, etc) _____

Do you smoke? Yes No Packs per day _____ Cigars or other _____

Do you use smokeless tobacco? Yes No

Do you drink alcohol? Yes No Drinks per day ___ Per month ___ Per week ___ Occasional ___

Please list any other physicians who have treated you feet and when: _____

Do you use any recreational/street drugs: Never Rare Daily Type _____

Please list any other doctors you are seeing and why: _____

Medical History – Please note if you have, or have had any of the following:

Past Now

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | other Liver Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis: Rheumatoid – osteoarthritis | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Problems Hearing Aid? <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | HIV positive or Aids |
| <input type="checkbox"/> | <input type="checkbox"/> | Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Problems | <input type="checkbox"/> | <input type="checkbox"/> | Immune system problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer: Type& When _____ | <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain/Stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulation Problems | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression or Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | Keloids |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes: date of Diagnosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease COPD Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Digestive Problems | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Problems | <input type="checkbox"/> | <input type="checkbox"/> | Nerve Disorder Type _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Numbness Where _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Gout | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis / Osteopenia |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems | <input type="checkbox"/> | <input type="checkbox"/> | Phlebitis/ Blood Clots |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack Date _____ | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever / Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Elevated Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Thirst | <input type="checkbox"/> | <input type="checkbox"/> | Skin Rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Ulcers: _Peptic _Duodenal |
| <input type="checkbox"/> | <input type="checkbox"/> | Healing problems | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A, B, C or other _____ | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicose Veins | <input type="checkbox"/> | <input type="checkbox"/> | Polio |

Are you Pregnant? Yes No Due Date ___ ___ ___ Are you breast feeding? Yes No

Do you have any metal implants, screws, pins, etc? Yes No Where? _____

Do you have a Pacemaker or defibrillator? Yes No

Any Other medical problems not listed? _____

Family History: Please list any diseases common to your family such as diabetes, heart problems, Arthritis, genetic problems etc.

Mother: _____ Father: _____

Siblings: _____

Any other comments? _____
