

## MEDICAL HISTORY

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

What foot problem(s) bring you to our office: \_\_\_\_\_

\_\_\_\_\_

Have you injured your foot? How? \_\_\_\_\_

\_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Last Exam Date: \_\_\_\_\_

Please list all medicines which you now use: \_\_\_\_\_

\_\_\_\_\_

Please list any operations and give approximate dates: \_\_\_\_\_

\_\_\_\_\_

### CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE/HAD:

Congenital Heart Disease

Cardiovascular Disease

High Blood Pressure

Poor Circulation

Stroke

Fainting Spells

Diabetes

Hepatitis

Liver Problems

Jaundice

Kidney Problems

Stomach Ulcers

Arthritis

Aids

Gout

Blood Clots

Venereal Disease

Cancer

Others (please list) \_\_\_\_\_

Do you bruise easily?

Yes  No

Do you have any blood disorders?

Yes  No

Have you ever had foot/ankle surgery?

Yes  No

When? \_\_\_\_\_ By Whom? \_\_\_\_\_

When you cut yourself, do you heal easily?

Yes  No

Do you smoke?

Yes  No How Much? \_\_\_\_\_

Do you drink?

Yes  No How Often? \_\_\_\_\_

Women – Are you pregnant?

Yes  No

Have you ever had any complications or serious problems with previous treatment?  Yes  No

Please Explain \_\_\_\_\_

What is your weight? \_\_\_\_\_

What is your shoe size? \_\_\_\_\_

### ARE YOU ALLERGIC OR ADVERSELY AFFECTED BY ANY OF THE FOLLOWING:

Local Anesthetics

Penicillin

Antibiotics

Sulfa Drugs

Barbiturates

Sedatives

Sleeping Pills

Iodine

Codeine

Topical Solutions

Adhesive Tape

Mole Skin

Felt or Glue

Other \_\_\_\_\_

\_\_\_\_\_