Medical History

Name____Date______________________

EXPLAIN YOUR FOOT COMPLAINTS____

Primary Care Physician_____________________________Last Exam Date_______________

Previous surgeries:____
Medications Being Taken:____

CHECK ANY OF THE FOLLLOWING CONDITIONS THAT YOU HAVE/ HAD:

_____Congenital Heart Disease
_____High Blood Pressure
_____Stroke
_____Diabetes
_____Liver Problems
_____Kidney Problems
_____Arthritis
_____Gout
_____Venereal Disease
_____Others (please list)

_____Cardiovascular Disease
_____Poor Circulation
_____Fainting Spells
_____Hepatitis
_____Jaundice
_____Stomach Ulcers
_____Aids
_____ Blood Clots
_____Cancer

Do you bruise or bleed easily?____Do you have any blood disorders such as anemia?______

Have you ever had foot/ ankle surgery?_____When?______By whom?__________________
Have you ever had any complications or serious problems with previous treatment?_______
Please explain____
When you cut yourself, do you heal easily?____________Do you smoke?_______________
Do you drink?_______How much?______________What is your shoe size?_____________
What is your weight?________________Women-are you pregnant?____________________

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

_____Local Anesthetics
_____Sulfa Drugs
_____Sleeping Pills
_____Topical Solutions
_____Felt or Glue

_____Penicillin
_____Barbiturates
_____Iodine
_____Adhesive Tape
_____Other____

_____Anitibiotics
_____Sedatives
_____Codeine
_____Mole Skin