Medical History

General History

Full Name: ______________________________ Occupation: ____________________

Gender: (circle) M or F Age: ________ DOB: ______________ Weight: ________ Height: ________ Shoe Size: _______

Chief Complaint: ________________________ Family Doctor: ____________________ Last Seen: ________

Would you say your health is: Good/Fair/Poor. Do you think you might be pregnant? Yes/No

Smoking: Packs/day: Years: Past Smoker: Packs/day Years: _______

Caffeine: yes/no Quantity_________ Alcohol: None Rarely Moderately Daily Quit

Recreational Drug Use: None Moderately Daily Quit

List Athletic activities: ____________________________ Amount per day/week: ______________________________

Employment requires you to: (circle which apply) Sit Stand Sit and Stand Stand and Walk Not Employed

Have you ever been to a Podiatrist before: Yes/No. If yes, please list. Name: ____________________ Last Seen: ________

Have you ever worn orthotics/arch supports? Yes/No. If yes, what kind: ______________________________________

How did you hear about us? ____

Do you have or have you ever been treated for: (circle items to indicate YES)

AIDS/HIV	Bunions	Fibromyalgia	Low Blood Pressure	Special Diet
Anemia	Chest Pain	Flat Feet	Lung Disease	Sports Related Injuries
Angina	Chemical Dependency	Gout	Nervous Problems	Stomach Ulcers
Ankle Pain	Cancer	Headaches	Osteoporosis	Stroke
Arthritis	Circulatory Problems	Heart Disease	Phlebitis	Swelling in Ankles/Feet
Artificial Valves	Corns and Calluses	Heel Pain	Plantar Warts	Tired Feet
Artificial Joints	Depression	Hemophilia	Radiation Treatment	Thyroid Disorder
Asthma	Diabetes	High Blood Pressure	Rash	Tuberculosis
Athlete's Foot	Ear Problems	Ingrown Toenails	Rheumatic Fever	Varicose Veins
Back Problems	Eye Problems	Kidney Problems	Seizure Disorders	Venereal Disease
Bleeding Disorders	Fainting	Liver Disease	Sinus Problems	Weight Loss, unexplained

Sensation History: Night Pain Burning Tingling Cramps/Numbness in Feet or Legs Calf Pain

Pain Level: Please circle the number on the pain scale that best represents your level of pain at this moment.

0________1________2________3________4________5________6________7________8________9________10

(zero: NO Pain) *(ten: Worst possible pain)*

Family History

List Relationship to you of family members who have had: Foot Problems: ____

Arthritis:______________________ Diabetes:______________________ Heart Problems: ____________________

Past Surgical Procedures

Please list the surgeries and dates that you have had:____

____

Previous Blood Transfusions: Yes/ No Exposure to Hepatitis: Yes/ No

Medications (please attach additional list if they apply)

Include prescriptions, over-the-counter medications and vitamins: __________________________________

____

Pharmacy Name:________________________ Location: __________________ Phone #:__________________

Allergies

Are you allergic to any of the following: (circle what applies and note any reactions) or CIRCLE: **No Known Allergies**

Adhesive/Tape: ________________ Anticoagulants: ________________ Aspirin: ____________________

Codeine: ____________________ Demerol: ____________________ Iodine: ____________________

Local Anesthetics: ______________ Novocain: __________________ Penicillin: __________________

Seafood: ____________________ Sulfa: ______________________ Other:______________________

Print Patient's Name: ____________________ Signature of Patient/Guardian: ________________ Date: _________