

## MEDICAL INFORMATION

This Information is Important For Our Records and Your Health

Describe your foot problem \_\_\_\_\_

Have you tried anything to treat the problem? \_\_\_\_\_

How long has it been bothering you? Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years \_\_\_\_\_

Please indicate which foot problems you now have or have had in the past:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ankle Pain         | <input type="checkbox"/> Athlete's Foot             | <input type="checkbox"/> Bunions          |
| <input type="checkbox"/> Corns and Calluses | <input type="checkbox"/> Numbness in Feet or Legs   | <input type="checkbox"/> Flat Feet        |
| <input type="checkbox"/> Foot or Leg Cramps | <input type="checkbox"/> Heel Pain                  | <input type="checkbox"/> Ingrown Toenails |
| <input type="checkbox"/> Plantar Warts      | <input type="checkbox"/> Swelling in Ankles or Feet | <input type="checkbox"/> Tired Feet       |

Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

### 3 ALLERGIES

Are you allergic to or sensitive to:

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Adhesive/Tape  | <input type="checkbox"/> Anesthetics  |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Novocain     |
| <input type="checkbox"/> Aspirin        | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Codeine        | <input type="checkbox"/> Seafood      |
| <input type="checkbox"/> Demerol        | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Iodine         | <input type="checkbox"/> Others _____ |

### 4 MEDICATIONS

What medications do you take regularly?

Please include prescriptions, over-the-counter medications, and vitamins.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Pharmacy or Drug Store:

\_\_\_\_\_  
Phone # \_\_\_\_\_

### 5 GENERAL HEALTH INFORMATION

Do you have **diabetes**? Yes No If yes, do you take insulin? Yes No Number of years that you've had diabetes \_\_\_\_\_

Please list any surgeries you have had \_\_\_\_\_

Hospitalizations other than for the surgeries listed \_\_\_\_\_

Are you under a physician's care? Yes No If yes, for what condition? \_\_\_\_\_

Physician \_\_\_\_\_ Date you last saw this Doctor \_\_\_\_\_

May we contact your physician about your health? Yes No Physician's Phone Number \_\_\_\_\_

Do you smoke? Yes No Number of packs per day \_\_\_\_\_ How many years have you smoked? \_\_\_\_\_

Did you previously smoke? Yes No Number of years \_\_\_\_\_

Do you drink alcohol or beer? Yes No If yes, how much? Less than 1-2 per week 1-2 per day More than 2 per day

Do you drink caffeinated beverages? Yes No Number of cups/cans per day \_\_\_\_\_

Employment: Sit at job \_\_\_\_\_ Stand at job \_\_\_\_\_ Stand & walk at job \_\_\_\_\_ Retired \_\_\_\_\_ Homemaker \_\_\_\_\_

Athletic activities in which you participate. (please list and indicate frequency) \_\_\_\_\_

## MEDICAL INFORMATION

This Information is Important For Our Records and Your Health

### 6 MEDICAL HISTORY

Please check which best describes your general health: Excellent Good Fair Poor

Please check any of the following you have, or have had a problem with in the past:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Aids/HIV             | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Nose Problems                   |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Eye problems           | <input type="checkbox"/> Phlebitis                       |
| <input type="checkbox"/> Angina               | <input type="checkbox"/> Fainting/Dizziness     | <input type="checkbox"/> Psychiatric Disorders           |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Foot or Leg Cramps     | <input type="checkbox"/> Respiratory Disorders           |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Frequent Infection     | <input type="checkbox"/> Rheumatic Fever                 |
| <input type="checkbox"/> Back Problems        | <input type="checkbox"/> Gout                   | <input type="checkbox"/> Shortness of Breath             |
| <input type="checkbox"/> Bleeding Disorders   | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Slow or non-healing wounds      |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Stomach ulcers                  |
| <input type="checkbox"/> Chemical Dependency  | <input type="checkbox"/> Hemophilia             | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Swelling of the feet/ankles     |
| <input type="checkbox"/> Chronic Diarrhea     | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Tuberculosis                    |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Unexplained fever / weight loss |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Varicose Veins                  |
| <input type="checkbox"/> Ear problems         | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Venereal Disease                |

Do you have any artificial joints?

Hip  Yes  No Right / Left

Knee  Yes  No Right / Left

Do you have a Heart Valve Implant or Murmur?  Yes  No

Women Only: Are you pregnant?  Yes  No Breastfeeding?  Yes  No Taking Oral Contraceptives?  Yes  No

### 7 FAMILY HISTORY

MOTHER	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of Death _____
FATHER	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of Death _____
BROTHER	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of Death _____
SISTER	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of Death _____

Is there a family (blood relative) history of any of the following medical problems:

- |   |                                     |  |                                   |
|---|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Bleeding Disorder                       | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Stroke     | <input type="checkbox"/> Circulation problems of the legs / feet |                                   |
| <input type="checkbox"/> Bunions              | <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Flatfeet                                |                                   |

### 8 CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to examine, administer and after consultation, perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my feet.

---

Signature

Date