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: 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? ______________________________

History Of : Do you have or have you ever been treated for: (circled 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 Heart 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 Swelling 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/other Hospitalization:

Surgical History	Date	Hospitalization History	Date
______________	________	______________	________
______________	________	______________	________

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: _______