

MEDICAL INFORMATION

This information Is Important For Our Records And Your Health

Describe your foot problem_____

How long has it been bothering you? _____Days _____Weeks _____Years
Any past problems of your feet and ankles?_____

Any past surgical procedures on your feet or ankles?_____

Shoe Size_____Current Weight_____ Height_____

Are you allergic or sensitive to:
Antibiotics (Penicillin,Sulfa drugs,etc?) _____
Any Medicines_____
Tape?_____ Betadine(iodine)?_____ Other_____
Have you had problems taking aspirin or ibuprofen(Advil,Motrin)?_____
Yes_____ No_____
Any problem with local anesthetics(Novocaine,Lidocaine)? Yes_____ No_____

GENERAL HEALTH INFORMATION

Do you have Diabetes? Yes_____ No_____ If yes, do you take insulin? Yes_____ No_____
Number of years _____

Have you had any serious illnesses?_____

Have you had any major surgeries?_____

Are you under a physician's care? Yes_____No_____ If yes, for what condition_____

Family Physician_____Date you last saw this Doctor_____

May we contact your physician about your health? Yes_____No_____

Name of your Pharmacy or Drug Store_____Phone #_____

What medications do you take regularly?_____

Check () any of the following you have, or have had a problem with:

- | | | | |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Asthma | <input type="checkbox"/> Skin | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Circulation | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Gout | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hormones | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Healing |
| <input type="checkbox"/> Kidneys | <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Bladder | <input type="checkbox"/> Liver | <input type="checkbox"/> Intestines |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | | |

Do you have any artificial joints?

Hip Yes_____ No_____

Knee Yes_____ No_____

Other _____

Do you have Heart Valve Implant? Yes_____ No_____

Family History

Mother Living _____ Deceased_____ Cause of Death_____

Father Living _____ Deceased_____ Cause of Death_____

Brother Living _____ Deceased_____ Cause of Death_____

Sister Living _____ Deceased_____ Cause of Death_____

Is there a family (blood relative) history of:

Heart Disease

Arthritis

Bleeding Disorder

Neurological Disorder

Stroke

Bunions

Hammertoes

Flatfeet

Circulation problems in legs or feet

Do you smoke? Yes_____ # packs per day_____ No_____

Previously smoked? Yes_____ # of years_____ No_____

Do you drink alcohol or beer? Yes_____ No_____

Light usage 1-2 per week Moderate, 1-2 per day Heavy, more than 2 daily

Employment: Sits at job Stands at job Stands & walks at job Retired

Signature_____ Date_____