MEDICAL INFORMATION

Describe your foot problem: _____

_____

_____

How long has it been bothering you? _____ Days _____ Weeks _____ Months _____ Years
Is this the result of any injury? Yes No If yes, when, where and how did the accident happen? _____

_____

Have you had any past problems with your feet or ankles? Yes No If yes, please describe:

_____

_____

Any past surgical procedures on your feet or ankles? Yes No If yes, please list surgeries:

_____

_____

Shoe size _____ Current weight _____ Current height _____

List any medications you are allergic to: _____

_____

Have you had any problems with local anesthetics? Yes No

Do you have diabetes? Yes No If yes, year diagnosed _____ Do you take insulin?
Yes No Physician that manages your diabetes: _____
What was your latest blood sugar or A1C reading? _____

Have you ever been diagnosed with MRSA? Yes No If so, when? _____

List ANY medical conditions that you are currently being treated for: _____

_____

_____

List ANY surgical procedures that you have had: _____

_____

_____

List ALL medications (prescription and over the counter) that you take on a daily basis: _____

_____

_____

Pharmacy name and phone number _____

Check any of the following that you are currently being treated for or have been treated for in the past:

_____ Heart disease _____ Asthma _____ Weight gain/loss _____ Skin

_____ Frequent infections _____ Circulation _____ Stomach ulcers _____ Gout

_____ Arthritis _____ Hormones _____ Tuberculosis _____ Healing

_____ Kidney disease _____ Neurological _____ Rheumatic fever _____ Anemia

_____ Respiratory _____ Bladder _____ Intestines _____ Liver

_____ High blood pressure _____ Cancer _____ MRSA _____ Stroke

Do you have any artificial joints or implants? Yes No If yes, where? _____

Do you have a heart valve implant? Yes No

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 history (blood relative) of any of the following:

_____ Heart disease _____ Arthritis _____ Neurological disorder

_____ Bleeding disorder _____ Stroke _____ Circulatory problems

_____ Bunions _____ Hammertoes _____ Flatfeet

Do you smoke? Yes No If yes, how many packs per day? _____ How long? _____
Previously smoked? Yes No # of years _____

Alcohol consumption? Yes No _____ Light usage 1-2 per week _____ Moderate usage 1-2 per day _____ Heavy usage more than 2 daily.

Employment/Activity level : _____ sits _____ stands _____ stands and walks