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 and 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 any problems taking aspirin or Ibuprofen (Advil, Motrin)? ❒ Yes ❒ No

Any problems with local anesthetics (Novocaine, Lidocaine)? ❒ Yes ❒ No

GENERAL HEALTH INFORMATION

Do you have diabetes? ❒ Yes ❒ No If yes, do you take insulin? ❒ Yes ❒ No

Do you have HIV? ❒ Yes ❒ No Do you have hepatitis? ❒ Yes ❒ No

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:

( ) Heart	( ) Asthma	( ) _____	( ) Unexplained weight loss
( ) Circulation	( ) Stomach Ulcers	( ) Gout	( ) Frequent infections
( ) Arthritis	( ) Hormones	( ) Tuberculosis	( ) Healing
( ) Kidneys	( ) Anemia	( ) Rheumatic Fever	( ) Neurological Disorder
( ) Lungs	( ) Bladder	( ) Liver	( ) Intestines
( ) Cancer	( ) High Blood Pressure		

Do you have any artificial joints: Hip ❒ Yes ❒ No

Knee ❒ Yes ❒ No

Other: _____

Do you have a 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 (close relative) history of:

( ) Heart Disease
( ) Bleeding Disorder
( ) Neurological Disorder
( ) Stroke
( ) Bunions
( ) Hammertoes
( ) Flat feet
( ) Circulation problems in legs or feet

Do you smoke? ❒ No ❒ Yes # packs/day: _____

Did you previously smoke? ❒ No ❒ Yes # years: _____ # packs/day: _____

Do you drink alcohol or beer? ❒ No ❒ Yes

( ) Light usage (1-2/week) ( ) Moderate (1-2/day) ( ) Heavy (more than 2 a day)

Employment: ( ) Sits at job ( ) Stands at job ( ) Stands and walks at job ( ) Retired

Signature: _____ Date: _____