MEDICAL HISTORY

Name _____ Date _____/_____/_____ DOB _____/_____/_____ Age ____ Male ____Female ____

Weight ____ Height ____ Shoe Size ____ Shoe Width ____ Occupation _____

CHIEF COMPLAINT: (History of Current Complaint)

Illness ____ How long have you had this condition? _____ Describe Condition _____

_____

_____

Injury Yes ____ No ____ If injury, is this work related? Yes ____ No ____ If injury, how, when, and where did it happen? _____

_____

_____

What previous treatment have you had for this condition or injury? Did it help and give relief? _____

_____

Please Mark Yes or No	YES	NO
1. Women: Are you pregnant or trying to get pregnant?	____	____
2. Are you now or have you been under a physician's care during the past 2 years?	____	____
3. Are you subject to prolonged bleeding?	____	____
4. Are you subject to nervous disorders, fainting, or dizziness?	____	____
5. Have you experienced any ill effects from Penicillin, Cortisone, Aspirin, Sulfa, or Local Anesthetics?	____	____
6. Have you had any injuries to your feet, ankles, legs, or back? If yes, please describe below:	____	____

_____

Do you have, or have you had, any of the following?

AIDS/HIV	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Renal Dialysis	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Rheumatic Fever	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Rheumatism	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Scarlet Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Shingles	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Hives or Rash	O Yes O No	Sickle Cell Disease	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hypoglycemia	O Yes O No	Sinus Trouble	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Irregular Heartbeat	O Yes O No	Spina Bifida	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Kidney Problems	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Leukemia	O Yes O No	Stroke	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Liver Disease	O Yes O No	Swelling of Limbs	O Yes O No
Breathing Problem	O Yes O No	Frequent Headaches	O Yes O No	Low Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Lung Disease	O Yes O No	Tonsillitis	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tuberculosis	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Cold Sores/Fever Blister	O Yes O No	Heart Murmur	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pace Maker	O Yes O No	Radiation Treatments	O Yes O No	Yellow Jaundice	O Yes O No
Convulsions	O Yes O No	Heart Troubles/Disease	O Yes O No	Recent Weight Loss	O Yes O No		

Have you ever had any serious illness not listed above? Yes ____ No ____ If yes, please explain: _____

_____

HOSPITALIZATIONS / SURGERIES

_____

_____

MEDICATIONS: (list drug name, dosage, frequency, and condition/disease)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

OVER-THE-COUNTER MEDICATIONS, VITAMINS AND HERBS

1. _____ 2. _____ 3. _____

ALLERGIES (include drugs, food, topical medications, and antibiotics)

1. _____ 2. _____ 3. _____

FAMILY HISTORY

Diabetes _____ Heart Disease _____ Hypertension _____ Cancer _____ Similar Foot Conditions _____

_____

SOCIAL HISTORY

Coffee Reg/Decaf # of cups _____ daily Soda Reg/Decaf # of cups _____ daily Alcohol # of drinks _____ daily/weekly/occasionally
Tobacco _____ type and frequency _____