MEDICAL HISTORY

Please put an X to indicate if you have/or had any of the following:

___ AIDS/HIV
___ Allergies to Anesthetics
___ Anemia
___ Asthma
___ Back Problems
___ Bleeding Disorders
___ Cancer
___ Chemical Dependency
___ Chest pain
___ Diarrhea
___ Diabetes (Please Circle) pills, insulin, diet
___ Ear Problems
___ Epilepsy
___ Eye Problems
___ Fainting
___ Foot or leg Cramps
___ Gout
___ Headaches
___ Heart Disease
___ Heart Attack
___ Hepatitis
___ High Blood Pressure
___ Itching Skin
___ Kidney Problems
___ Liver Disease
___ Low Blood Pressure
___ Muscle Pain
___ Nervous Problems
___ Neuropathy/Numbness
___ Respiratory Disease
___ Shortness of Breathe
___ Sinus Problems
___ Stroke
___ Swelling in Ankles and Feet
___ Swollen Neck Glands
___ Tired Feet/weakness
___ Tuberculosis
___ Ulcers
___ Varicose Veins
___ Venereal Disease
___ Weight loss unexplained
___ Other
_____
_____
_____
_____

SURGERIES YOU HAVE HAD_____

_____

_____

REASON FOR TODAYS VISIT: (LEFT, RIGHT, BOTH) _____

_____

_____

DURATION OF SYMPTOMS _____

LAST BLOOD PRESSURE _____-_____ LAST GLUCOSE _____ ML/DL

HEIGHT_____ WEIGHT_____ SHOE SIZE_____

HAVE YOU BEEN TREATED FOR THE SAME CONDITION IN THE PAST_____

IF YES, PLEASE EXPLAIN WHICH DOCTOR AND TREATMENTS RECEIVED_____

_____

_____

MEDICATIONS

INCLUDE PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS AND VITAMINS_____

_____

_____

SMOKER (YES OR NO) HOW MANY PACKS_____ HOW LONG_____

ALLERGIES

_____

_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be necessary in the diagnosis and/or treatment of my feet.

PATIENT SIGNATURE_____DATE_____