

Reason for your visit today

How long has it been bothering you? Days Weeks Months Years

Any past problems with your feet and/or ankles? NO YES If yes, please explain

Shoe Size Current Weight Height

Are you allergic to any medications? NO YES If yes, please answer the questions below

Allergy to antibiotics? Other medications?

Other allergies (ie. Tape, Adhesive, Iodine, Latex, etc...)

Have you had any problems with local anesthetics? NO YES If yes, please list:

GENERAL HEALTH INFORMATION

Do you have DIABETES? NO YES If yes, do you take insulin? What kind?

Is there a family history of DIABETES? NO YES If yes, please explain

Do you have a history of a HEART PROBLEM? NO YES If yes, please explain

Any history of a serious illness?

Any history of surgeries?

Are you currently under a physicians care? NO YES If yes, please explain

YOUR PHYSICIAN / Dr. M.D. PHONE #:

Physician address City State Zip code

Date you last saw this doctor? Pharmacy name and phone #:

Please list all medications including otc's and what they are used for:

.....
.....

CHECK ALL THAT YOU HAVE OR HAVE HAD A PROBLEM WITH:

- | | | | |
|--|---|--|---|
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Slow Healing | <input type="radio"/> Gout | <input type="radio"/> Mitral Valve Prolapse |
| <input type="radio"/> Liver Problems | <input type="radio"/> Frequent Infections | <input type="radio"/> Hypothyroidism | <input type="radio"/> Kidney Problems |
| <input type="radio"/> Rheumatic Fever | <input type="radio"/> High Cholesterol | <input type="radio"/> Arthritis | <input type="radio"/> Stroke |
| <input type="radio"/> Anemia | <input type="radio"/> Ankle/Feet Swelling | <input type="radio"/> Headaches | <input type="radio"/> Bleeding Disorder |
| <input type="radio"/> Numbness in Feet | <input type="radio"/> Neurological Problems | <input type="radio"/> Lung Disorder | <input type="radio"/> Skin Disorder |
| <input type="radio"/> Psychiatric Problems | <input type="radio"/> Asthma | <input type="radio"/> Circulation Problems | <input type="radio"/> HIV Positive |
| <input type="radio"/> Stomach Ulcers | <input type="radio"/> Back Pain | <input type="radio"/> Hepatitis B Positive | <input type="radio"/> Blood Clots or DVT's |

IS THERE A FAMILY HISTORY (BLOOD RELATIVE) OF THE FOLLOWING:

- | | | | |
|---|---|--|------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bunions | <input type="checkbox"/> Circulation Problems
in feet or legs | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Stroke | <input type="checkbox"/> Flat Feet |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | | |

Do you smoke? NO YES If yes, # packs per day

Previously Smoked? NO YES If yes, for how long?

Do you drink Alcohol? NO YES **If yes, how much?** 1-2 drinks per week 2 drinks per day More than 2 daily

Employment Conditions: Sits a Job Stands at Job Stands & Walks at Job Retired

Patient Name **Patient/ Guardian Signature** **Date**

Thank you.