

## **MEDICAL INFORMATION**

*This Information is important for our Records and your Health*

Describe your foot problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has it been bother you? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Years

Any past problems with your feet or ankles? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any past surgical procedures on your feet or 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 problems taking aspirin or ibuprofen (Advil, Motrin, etc) Yes \_\_\_\_\_ No \_\_\_\_\_
- Any Problems with local anesthetics (novacane, Lidocaine)? Yes \_\_\_\_\_ No \_\_\_\_\_

## **GENERAL HEALTH INFORMATION**

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

Number of Years: \_\_\_\_\_

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 medication do you take on a regular basis? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE, OR HAD A PROBLEM WITH:

- |                                      |                                       |  |                                     |
|--------------------------------------|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> HEART       | <input type="checkbox"/> ASTHMA       | <input type="checkbox"/> HIGH BLOOD PRESSURE     | <input type="checkbox"/> DIABETES   |
| <input type="checkbox"/> CIRCULATION | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> STOMACH ULCERS          | <input type="checkbox"/> LIVER      |
| <input type="checkbox"/> ARTHRITIS   | <input type="checkbox"/> HORMONES     | <input type="checkbox"/> RHEUMATIC FEVER         | <input type="checkbox"/> HEALING    |
| <input type="checkbox"/> KIDNEYS     | <input type="checkbox"/> ANEMIA       | <input type="checkbox"/> FREQUENT INFECTIONS     | <input type="checkbox"/> INTESTINES |
| <input type="checkbox"/> LUNGS       | <input type="checkbox"/> BLADDER      | <input type="checkbox"/> NEUROLOGICAL DISORDER   | <input type="checkbox"/> GOUT       |
| <input type="checkbox"/> CANCER      | <input type="checkbox"/> SKIN         | <input type="checkbox"/> UNEXPLAINED WEIGHT LOSS |                                     |

DO YOU HAVE ANY ARTIFICIAL JOINTS?

HIP YES \_\_\_\_\_ NO \_\_\_\_\_

KNEE YES \_\_\_\_\_ NO \_\_\_\_\_

OTHER \_\_\_\_\_

DO YOU HAVE A HEART VALVA 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 (BLOOD RELATIVE) HISTORY OF:

- HEART DISEASE
- ARTHRITIS
- BLEEDING DISORDER
- NEUROLOGICAL
- STROKE
- BUNIONS
- HAMMERTOES
- FLAT FEET
- CIRCULATION PROBLEMS IN THE LEGS OR FEET

DO YOU SMOKE? YES \_\_\_\_\_ # OF PACKS PER DAY \_\_\_\_\_ NO \_\_\_\_\_

PREVIOUSLY SMOKED? YES \_\_\_\_\_ NUMBER OF YEARS \_\_\_\_\_ NO \_\_\_\_\_

DO YOU DRINK ALCOHOL OR BEER? YES \_\_\_\_\_ NO \_\_\_\_\_  LIGHT USAGE, (1-2 WEEK)

MODERATE USAGE (1-2 DAY)  HEAVY, M (MORE THAN 2 / DAY)

EMPLOYMENT  SITS AT JOB  STANDS AT JOB  STANDS & WALKS AT JOB  RETIRED

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_