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Medical History

Patient Name: _____ Date of Birth: _____ Age: _____

Please describe your foot problems: _____

Have you been treated for this problem? () Yes () No If yes, what has been done?

Have you had any previous foot care? () Yes () No If yes, what have you had done and by whom? _____

General Health

Height: _____ Weight: _____ Shoe size: _____

(Please check any of the following, which you or your family have been or are being treated)

Self Family

Arthritis (type) _____
 Mitral Valve prolapse
 High blood pressure (hypertention)
 Heart disease (cardiac problems)
 Peripheral Vascular Disease (circulation)
 Gout
 Stroke
 Diabetes
 Liver disease
 HIV positive
 Neuropathy
 Other- Please state: _____

Self Family

Asthma
 Glaucoma
 Breathing Problems
 Hemophilia (bleeding disorders)
 Stomach Problems (ulcers)
 Renal disease (kidney problems)
 Phlebitis (blood clots)
 Anemia
 Thyroid problems
 Slow healer
 Congestive Heart Failure
 Previous transfusions (if yes, when): _____

Women, are you pregnant? () Yes () No If Yes, due date: _____

Allergies: Are you allergic to any of the below? Please check

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Novocaine	<input type="checkbox"/> Cortisone	<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Codeine
<input type="checkbox"/> Iodine Dye	<input type="checkbox"/> Caffeine	<input type="checkbox"/> Tape	

Other: _____

Personal Social History:

Tobacco: _____ packs per day for _____ years.

Alcohol: _____ oz. per week. Caffeine: _____ cups per day.

Occupation: _____

Fitness activities: _____ How much per week: _____

Medications: (please list all medications, vitamins, or supplements)

_____	_____
_____	_____
_____	_____
_____	_____

Surgeries/Hospitalizations: (Please List) _____

Consent for Treatment

The above information is correct to the best of my knowledge and I consent to such diagnostic procedures and medical care as deemed necessary by the doctor for my treatment. I also consent to have photographs taken which will be used solely for medical education.

Today's date: _____

X _____

Signed: Patient/Guardian