



PLEASE TELL US ABOUT YOUR MEDICAL HISTORY
(indicate if you have had any of the following)

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> Hepatitis or Jaundice	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Anemia	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Special Diet
<input type="checkbox"/> Artificial Heart/Valves	<input type="checkbox"/> Ear Problems	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Swelling (Ankles/Feet)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Swollen Neck Glands
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Foot or Leg Cramps	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Headaches	<input type="checkbox"/> Rash	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Other: _____			

Have you had recent weight loss or weight gain? _____

Do you smoke? Yes No Quit Years smoked: _____ Packs per day: _____

Surgeries you have had _____

Hospitalization other than for the surgeries listed: _____

Family Physician: _____ Last visit date: ____/____/____

Are you now, or have you been, under any other doctor's care for any reason over the past two years?

Yes No

If yes, explain:

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins: _____

Pharmacy Name: _____
Phone: _____

Do you take oral contraceptives? Yes No

ALLERGIES

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Local Anesthesia |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Novocain |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Seafood |
| <input type="checkbox"/> Sulfa | |
| <input type="checkbox"/> Other: _____ | |

What would you like done today? _____

What (if any) are your expectations? _____

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 deemed necessary in diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____