MEDICAL HISTORY

NAME: _____ TODAY'S DATE_____

FOOT PROBLEMS (Please list all problems and reason for your visit):

1. _____ How Long: _____

2. _____ How Long: _____

3. _____ How Long:_____

Have you been treated in the past for any type of foot problem or have had foot surgery prior to your visit today?

( ) YES ( ) NO

If Yes, please list type of surgery / problem: _____

_____

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____

MEDICATIONS: (Please list all medications that you take on a regular basis

1. _____ 2._____

3. _____ 4._____

5._____ 6. _____

MEDICAL HISTORY: (Please check those that apply if you presently have or have had any of the following):

___Diabetes ___ High Blood Pressure ___Heart Problems

___Circulatory Problems ___Bleeding Disorder ___Cancer type: _____

___Alcohol Rare/Weekly/Daily ___Smoker #___packs per day / week ___Stomach Ulcers

___Reynaud's ___Hepatitis ___Kidney Disease

___Lung / Breathing Problems ___Tuberculosis ___ AIDS-HIV

___Arthritis ___Gout ___Drug Use

___Pregnancies #_____ ___Other _____

OPERATIONS: (Please list the types of operations you have had)_____

_____

ALLERGIES: please list reaction

___ None ___Penicillin _____ ___Sulfa _____

___Antibiotics _____ ___Codeine _____ ___Novocaine _____

___Steroids _____ ___Aspirin _____ ___Iodine _____

___Latex ___Other _____

I have read and completed the above history to the best of my ability. I asked for assistance from the doctor/staff as needed. I authorize release of above information to all sources as necessary to insure proper treatment and payment of services rendered.

Signature: _____Date:_____