MEDICAL INFORMATION

This information is Important For Our Records And Your Health

Describe your foot problem:

_____

_____

How long has it been bothering you? ___ Days _____Weeks ____Years.

Have you had any past problems with your feet and ankles?

_____

Have you had any past surgical procedures on your feet or ankles?

_____

Shoe size _____ Current weight _____ Height _____

Are you allergic or sensitive to:
a. Antibiotics (Penicillin, Sulfa drugs etc? _____
b. Any Medications_____
c. Tape _____Betadine (Iodine)_____Other_____

Do you have any problems taking aspirin or Ibuprofen (Advil, Motrin) Yes__No__
Any problem with local anesthetics (Novocaine, Lidocaine)? Yes____No____

GENERAL HEALTH INFORMATION

Do you have Diabetes? Yes__No__ Are you taking insulin? Yes___ No___
Number of years? ___

Have you ever been diagnosed with any serious illness, HIV AIDS?_____

_____

Have you ever 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 No: _____

What medications do you take regularly? _____

_____

PLEASE CHECK ( ) ANY OF THE FOLLOWING YOU HAVE, OR HAVE HAD, A PROBLEM WITH:

( ) Heart	( ) Asthma	( ) Skin	( ) Unexplained Weight Loss
( ) Circulation	( ) Stomach ulcers	( ) Gout	( ) Frequent Infections
( ) Arthritis	( ) Hormones	( ) Tuberculosis	( ) Healing
( ) Kidneys	( ) Anemia	( ) Rheumatic Fever	( ) Neurological Disorder
( ) Lungs	( ) Bladder	( ) Liver	( ) Intestines
( ) Cancer	( ) High Blood Pressure		

Do You Have Any Artificial Joints? Hip: Yes ____ No ____
Knee: Yes____ No ____
Other: _____

Have you had a heart valve 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 Family (Blood Relative) History of:

( ) Arthritis	( ) Heart Disease	( ) Stroke
( ) Bunions	( ) Bleeding disorder	( ) Flatfeet
( ) Hammertoes	( ) Neurological disorder	( ) Diabetes
( ) Circulation problems in the legs or feet		

Do You Smoke? Yes ____ Packs per day_____ No_____
Previously smoked Yes ____ # of years____ No____

Do you drink alcohol or beer? Yes ___ No ____
( ) Light usage 1-2 per week ( ) Moderate 1-2 per day ( ) Heavy more than 2 a day.

EMPLOYMENT: ( ) Sits at job ( ) Stands at job ( ) Stands & Walks at job ( ) Retired.

_____ _____
Signature Date