MEDICAL INFORMATION

Briefly describe your foot problem(s):____

How long has this problem existed:____

Current Height______________ Current Weight___________________ Shoe Size____________

ALLERGIES

Medication Allergies & Reaction:____

Latex Allergy: Y / N Tape Allergy: Y / N Contrast Dye Allergy: Y / N

MEDICATIONS

Current Medications (If you have a list give it to the secretary to copy.) ______________________

____

PRIMARY CARE DOCTOR & PHARMACY

Primary Care Doctor___________________________________ Date Last Seen PCP __________________________

Pharmacy____ Pharmacy Location __________________________

MEDICAL HISTORY

	YES	NO
Diabetes		
Heart Disease		
Hypertension		
Stroke		
Glaucoma		
Bleeding Issues		

	YES	NO
Kidney Disease		
Anemia		
Cancer		
AIDS/HIV		
Hepatitis		
Arthritis		

	YES	NO
Gout		
GI Ulcer		
Thyroid Problems		
Circulation Issues		
Liver Disease		
Heart Murmur		

Other Medical Conditions:____

SURGICAL HISTORY

List Surgical History & Hospitalizations: ____

____

FAMILY HISTORY

	YES	NO	Mother	Father
Diabetes				
Heart Disease				
High Blood Pressure				

	YES	NO	Mother	Father
Circulation Problems				
Cancer				
Other_______________				

SOCIAL HISTORY

Smoke? Y / N How many packs per day?_________ How many years? _______

Former Smoker? Y / N How long ago did you stop smoking? ________

Alcohol Consumption? Y / N How much? ________

Drug Use? Y / N If yes, what type? ____

Exercise? Y / N Brief Description: ____