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MEDICAL INFORMATION

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DESCRIBE YOUR FOOT PROBLEM
HOW LONG HAS IT BEEN BOTHERING YOU?DAYS WEEKSMONTHSYEARS WHAT PRIOR PROBLEMS HAVE YOU HAD WITH YOUR FEET, ANKLES, OR LEGS?
SHOE SIZE WEIGHT HEIGHT DO YOU HAVE ANY ALLERGIES?YesNo ALLERGY OR SENSITIVE TOPenicillin VicodinTapeCodeineAspirinAnestheticsIodineOther PLEASE LIST ALLERGIES
DO YOU HAVE ANY STOMACH DISORDERS?Yes No ANY PROBLEM TAKING ASPIRIN or IBUPROFEN?Yes No
GENERAL HEALTH INFORMATION
ARE YOU IN GOOD HEALTH? Yes No ARE YOU DIABETIC? Yes No IF YES, DO YOU TAKE INSULIN? Yes No WHAT DOSAGE DO YOU HAVE ANY ILLNESSES? Yes No IF YES DESCRIBE
WHAT OPERATIONS HAVE YOU HAD ?
ARE YOU CURRENTLY UNDER A PHYSICIANS CARE?Yes No
IF YES FOR WHAT CONDITION? DATE OF LAST VISIT TO DOCTOR ADDRESS AND TEL. NO. OF PHYSICIAN
DO YOU HAVE APROBLEM WITH ANY OF THE FOLLOWING? Heart Disease Poor Circulation High Blood Pressure Liver Disease Kidney Disease Skin Lungs Neurological Disorders Asthma Epilepsy Cancer Weight Loss Gout Frequent Infections Bladder Stomach or Intestines Anemia Prolonged Bleeding AIDS or related complex Blood Clots Varicose veins Other
DO YOU HAVE ANY ARTIFICIAL JOINTS OR IMPLANTS?Yes No DO YOU HAVE A HEART IMPLANT VALVE? yes no IS THERE A FAMILY HISTORY OF? _ Bad Feet Heart Disease Diabetes Circulation problemsHeart Attack DO YOU SMOKE?Yes No packs /day years Previously smoked Yes No packs /dayyears ALCHOHOLIC BEVERAGES? none rarely moderately dailyother OCCUPATION DOES YOUR JOB KEEP YOU ON YOUR FEET Yes No
SIGNATURE DATE