MEDICAL HISTORY

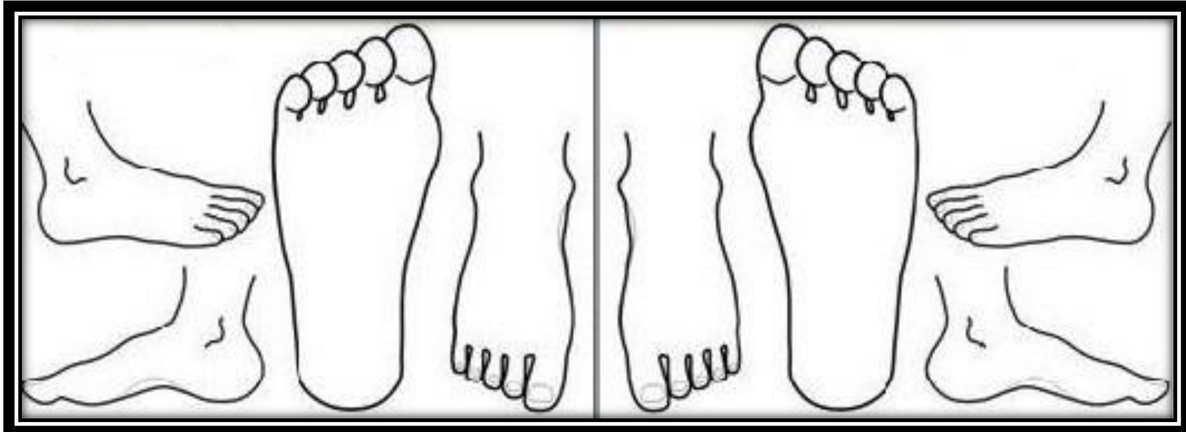
Name: ____

Height_________ Weight_________ Shoe Size_________ Do you wear inserts or orthotics? ____________

My chief complaint is:

____

Location: (circle)



Right Foot / Ankle Left Foot / Ankle

How long has this bothered you? ____

When do the symptoms bother you the most? ____

How did the symptoms begin? ____

What have you done to relieve the symptoms? ____

Who is your Primary Care Physician? _________________When were you last seen? ____________________

Do you currently smoke? _____________ How much? _____________ For how long? ___________________

If you do not smoke currently, are you a former smoker? ____

Do you currently drink? _____________ How much? ______________ For how long? ___________________

Do you use recreational drugs? ________ What kind? _____________ For how long? ___________________

Allergies: None known Adhesive Tape Penicillin Latex Iodine

List all allergies including your reaction: ____

____

List all medications and dosages that you are currently taking: ____

____

____

Have you had any foot or ankle surgeries in the past? ______ What kind? _________________ When? ______

____

List any previous surgeries along with the year it was performed: ____________________________________

____

Have you ever been hospitalized? _______ For what? _________________________________ When? ______

____

Have you ever had any post-operative infections? Yes No

Have you ever had MRSA? Yes No

Are you currently pregnant? Yes No

Do you now, or have you had in the past: (circle all that apply)

Aids/HIV	Diabetes Type I	Rheumatic Fever
Anemia	Diabetes Type II	Skin Disease
Osteoarthritis	Fainting or Dizzy Spells	Stroke
Rheumatoid Arthritis	Heart Attack	Ulcers
Asthma	Heart Disease	Varicose Veins
Bleeding Disorders	Hemophilia	High Cholesterol
Blood Clots	Hepatitis	Gout
Cancer	High Blood Pressure	Acid Reflux
Glaucoma	Liver Disease	Other: ____________________

Family Health History: (Include who has/had the illness, i.e. Mother, Father, Grandparents, Siblings)

Heart Attack ______________	Stroke _________________	High Cholesterol _______________
Diabetes _________________	Cancer _________________	High Blood Pressure ____________
Liver Disease ______________	Asthma ________________	Heart Disease _________________

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health or medications, I will inform the Doctor at my next appointment.

DATE __________ NAME (print) _________________________SIGNATURE ____________________________