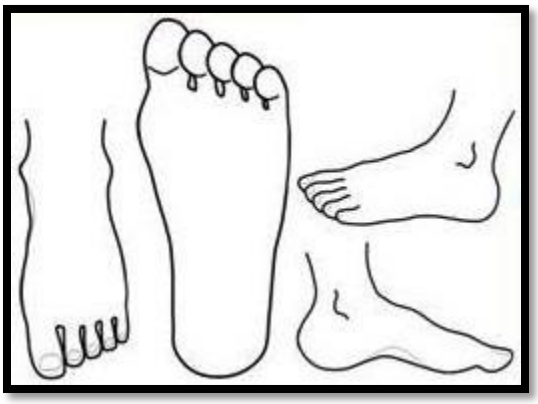
Medical History

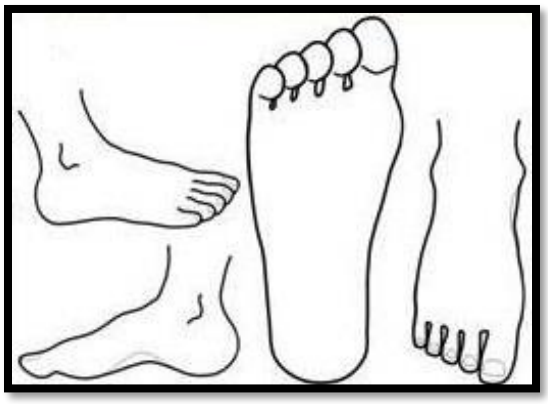
Patient Name: (Last, First, MI) _____DOB: _____

Primary Care Physician: (Name and Clinic) _____Date last seen? _____
Height: _____Weight: _____Shoe Size: _____Width: _____Do you wear Orthotics? Yes or No

What is the chief complaint for which you came to be treated?
_____

Location: (Circle) Left foot/ankle Right foot/ankle





When did the symptoms start? _____ How did it start? _____
Made worse or better by:_____
Previous Imaging: (X-rays, MRI, etc.) Yes / No Where/When was it completed: _____

Please indicate which foot problems you now have or have had in the past.

Foot/Ankle Pain	Yes / No	Bunions	Yes / No	Tired Feet	Yes / No
Corns or Calluses	Yes / No	Numbness	Yes / No	Swelling	Yes / No
Flat Feet	Yes / No	Foot/Leg Cramps	Yes / No	Heel Pain	Yes / No

Cigarette/Tobacco use? ( ) Never ( ) Previously; quit what year? _____ ( ) Current; _____ packs per day
Do you drink alcohol? ( ) No ( ) Daily ( ) Weekly ( ) Monthly For how many years? _____
Do you use recreational drugs? ( ) Yes ( ) No What kind?_____ For how many years? _____

Allergies: (*Circle all that apply)* ( ) No known drug allergies

Food:	Drug:	Environmental:
Gluten	Anticoagulant Therapy	Adhesive/Tape
Milk/Dairy	Aspirin	Dogs/Cats
Peanut	Codeine	Nickel
Seafood	Demerol	Pollen
Soy	Iodine	Mold
Eggs	Sulfa Drugs	Latex
Other: _____	Other: _____	Other: _____

Current Medications: (Include prescriptions, over the counter, and vitamins). ( ) I don't take any medication

Name:	Dosage:	Reason for use:

Medications continued:

Name:	Dosage:	Reason for use:

Past Surgical History: (Include **ALL** previous surgeries you have had).

Surgery:	Date:

Have you ever been hospitalized? ( ) Yes ( ) No For what? _____Date: _____
Have you ever had any post-operative infections? ( ) Yes ( ) No
Have you had MRSA? (Antibiotic resistant staph infection) ( ) Yes ( ) No
Are you currently pregnant? ( ) Yes ( ) No

Health History: (Please circle all diseases or disorders you have now or experienced in the past).

Cardiovascular:	**Dermatologic:**	**Eyes:**	**Psychiatric:**
Arrythmia	Callus	Cataract	Alcohol Abuse
Blood Clots	Cellulitis	Glaucoma	Anxiety
CHF	Rash	Diabetic Retinopathy	Depression
Heart Disease	Skin Lesion	**Hematologic/ Lymphatic:**	PTSD
High Blood Pressure	Ulceration	Anemia	Sleep Difficulty
High Cholesterol	Warts	Pulmonary Embolus	ADD/ADHD
Lymphedema	**Endocrine:**	Blood Clotting Problems	**Constitutional:**
Peripheral Vascular Disease	Diabetes Type I	**Musculoskeletal:**	Fever
Stroke	Diabetes Type II	Gout	Weight Loss
Low Blood Pressure	Hyperthyroid	Joint Pain	Weight Gain
Stroke	Hypothyroid	Muscle Weakness	Fatigue
Other: _____	Pre-diabetes	Osteoarthritis	**Respiratory:**
ENT:	**Gastrointestinal:**	Scoliosis	COPD
Acid Reflux	GERD	Spinal Stenosis	Asthma
Sleep Apnea	Hepatitis A, B, or C	Swelling	Emphysema

Anything additional health issues not listed above: _____

Family History: (Please circle whether anyone in your immediate family has ever experienced any of the following)
M= Mother, F= Father, S= Sibling

Heart Disease	M F S	Arthritis	M F S	Diabetes	M F S
High Blood Pressure	M F S	Cancer	M F S	Liver Disease	M F S
Bleeding Problems	M F S	Osteoporosis	M F S	Stroke	M F S
Diabetes	M F S	Stroke	M F S	Other: _____	M F S

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet/ankles.

Patient Signature: _____ Date: _____