PATIENT'S MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

PRESENT FOOT PROBLEM: _____

ALLERGIES:

	ALLERGY	REACTION
1.		
2.		
3.		
4.		
5.		

CURRENT MEDICATION: Please list **ALL** medications you take as well as the dosage of each and how many tablets are taken each day. You are required to bring a list of your medications with you to **EACH** visit.

	MEDICATION	DOSAGE	REASON		MEDICATION	DOSAGE	REASON
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

MEDICAL & FAMILY HISTORY: ***(Check only if Yes)***

	Self	Mother	Father		Self	Mother	Father
Arthritis: Type: _____	☐	☐	☐	High Cholesterol	☐	☐	☐
Asthma/Respiratory Disease	☐	☐	☐	HIV	☐	☐	☐
Back Problems	☐	☐	☐	Kidney Disease	☐	☐	☐
Bleeding Abnormalities	☐	☐	☐	Lameness or Leg Weakness	☐	☐	☐
Blood Clots	☐	☐	☐	Liver Disease	☐	☐	☐
Burning of Feet/Ankle/Legs	☐	☐	☐	Neuropathy	☐	☐	☐
Cancer: Type: _____	☐	☐	☐	Poor Circulation in Legs	☐	☐	☐
Cramping of Feet/Legs	☐	☐	☐	Pricking/Tingling Sensation	☐	☐	☐
Diabetes: Type I	☐	☐	☐	Rheumatic Fever	☐	☐	☐
Diabetes: Type II	☐	☐	☐	Scarring Tendency	☐	☐	☐
Gallbladder Disease	☐	☐	☐	Skin Disease Type: _____	☐	☐	☐
Gastrointestinal Problems	☐	☐	☐	Stroke	☐	☐	☐
Gout	☐	☐	☐	Swelling in Feet/Ankle/Legs	☐	☐	☐
Hearing Problems	☐	☐	☐	Temp changes (cold feet)	☐	☐	☐
Heart Disease	☐	☐	☐	Thyroid Disorders	☐	☐	☐
Hepatitis	☐	☐	☐	Visual Problems	☐	☐	☐
High Blood Pressure	☐	☐	☐	Other (Explain) _____	☐	☐	☐

PAST ACCIDENTS: Type of Accident and Date

1. _____

2. _____

PAST SURGERIES: Type of Surgery and Date

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

TOBACCO

Cigarettes – Current Smoker ☐ Formerly Smoked ☐ Never Smoked ☐ Unknown ☐
Cigar – Current Smoker ☐ Formerly Smoked ☐ Never Smoked ☐ Unknown ☐
Pipe – Current Smoker ☐ Formerly Smoked ☐ Never Smoked ☐ Unknown ☐
Smokeless Tobacco – Current Use ☐ Formerly Used ☐ Never Used ☐ Unknown ☐
If you currently use tobacco or did use tobacco, how much tobacco do you use a day? _____

ALCOHOL

Currently consumes alcohol ☐ Occasionally consumes alcohol ☐ Rarely consumes alcohol ☐
Denies alcohol use ☐ Has consumed alcohol in the past ☐ Never used alcohol ☐
Pipe – Current Smoker ☐ Formerly Smoked ☐ Never Smoked ☐ Unknown ☐

DO YOU USE RECREATIONAL DRUGS?

Current drug user ☐ Former drug user ☐ Never used drugs ☐

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____ **HOURS ON FEET DAILY:** _____

_____

PATIENT'S SIGNATURE *(PARENT/GUARDIAN)* **DATE**

_____

REVIEWED WITH PATIENT BY *(EMPLOYEE)* **DATE**