MEDICAL HISTORY

Last Name: _____ First Name: _____ Middle Initial: __

Present Foot Problem: _____

ALLERGIES:

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

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	CONDITION		MEDICATION	DOSAGE	CONDITION
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	☐	☐	☐	Temperature Changes (cold feet)	☐	☐	☐
Heart Disease	☐	☐	☐	Thyroid Disorders	☐	☐	☐
Hepatitis	☐	☐	☐	Visual Problems	☐	☐	☐
High Blood Pressure	☐	☐	☐	Other (Explain)	☐	☐	☐

Last Name: _____ First Name: _____ Middle Initial: __

PAST ACCIDENTS:

1. _____

2. _____

PAST SURGERIES:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

TOBACCO

Cigarettes: Current Smoke ☐ Former Smoked ☐ Never Smoked ☐

Cigar: Current Smoke ☐ Former Smoked ☐ Never Smoked ☐

Pipe: Current Smoke ☐ Former Smoked ☐ Never Smoked ☐

Smokeless Tobacco: Current User ☐ Former User ☐ Never Used ☐

If you currently use tobacco products, how much tobacco do you use a day? _____

ALCOHOL

Currently consumes alcohol ☐ Occasionally consumes alcohol ☐ Rarely consumes alcohol ☐
Never used alcohol ☐ Has consumed alcohol in the past ☐

DO YOU USE RECREATIONAL DRUGS?

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

HEIGHT: _____ **WEIGHT:** _____

Shoe Size: _____ **Hours on Feet Daily:** _____

What type of footwear do you usually wear? _____

_____

Patient Signature (Parent/Guardian) **DATE**

_____

Reviewed by Clinical Staff **DATE**