

MEDICAL HISTORY

NAME _____ DATE _____

YOUR MEDICAL DOCTOR'S NAME, PHONE AND ADDRESS _____

DATE OF LAST EXAM _____

WHAT PROBLEMS ARE YOU HAVING WITH YOUR FEET OR ANKLES? _____

WHAT MEDICATIONS DO YOU CURRENTLY USE ON A REGULAR BASIS OR ON AN OCCASSIONAL BASIS:

LIST RELATIONSHIP TO YOU OF IMMEDIATE FAMILY MEMBERS (MOTHER,FATHER, SIBLINGS) WHO HAVE HAD:

DIABETES _____ HEART DISEASE/ATTACKS _____
ARTHRITIS _____ HIGH BLOOD PRESSURE _____
STROKE _____ CANCER _____

ARE YOU NOW, OR MIGHT YOU BE PREGNANT? YES _____ NO _____

DO YOU SMOKE NOW? FORMER SMOKER _____ NO _____ YES _____ PACKS PER DAY _____ # OF YEARS _____

ALCOHOLIC BEVERAGE USE NONE _____ RARE _____ OCCASSIONAL _____ DAILY _____

LIST ANY EXCERCISE OR ATHLETIC ACTIVITIES YOU ARE ACTIVE IN _____

PERCENTAGE OF WAKING HOURS YOU SPEND ON YOUR FEET (CIRCLE ONE)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

DO YOU HAVE (PLEASE CIRCLE) ARTIFICIAL JOINTS, REPLACEMENT HEART VALVES, OR OTHER IMPLANTS

LIST PAST SURGERIES AND YEAR OF SURGERY _____

YOUR HEIGHT _____ YOUR WEIGHT _____ YOUR SHOE SIZE _____

DO YOU NOW OR HAVE YOU EVER BEEN TREATED FOR OR DIAGNOSED WITH THE FOLLOWING? PLEASE CIRCLE IF YES.

STROKE	CANCER	HIGH BLOOD PRESSURE
PHLEBITIS	HEART ATTACK	HEART CONDITION
DIABETES	ANEMIA	POOR CIRCULATION
HEPATITIS	ARTHRITIS	TUBERCULOSIS
GOUT	HIV/AIDS	NERVE DISORDER
ASTHMA	GLAUCOMA	KELOID/THICK SCAR
MIGRAINES	KIDNEY DISEASE	EPILEPSY/SIEZURES
LUNG DISEASE	LIVER DISEASE	THYROID DISORDER
REFLUX	SPINAL PROBLEMS	STOMACH ULCERS
PSYCHIATRIC DISORDER	OSTEOPOROSIS	HIGH CHOLESTEROL

OTHER(S) _____

NONE OF THE ABOVE _____

DO YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING? PLEASE CIRCLE IF YES.

SULFA	PENICILLIN
CODEINE	ADHESIVE TAPE
IODINE	LOCAL ANESTHETICS
ASPIRIN	ANY OTHER MEDICATIONS _____

NO KNOWN ALLERGIES _____