UPDATE_____ DATE_____

MEDICAL INFORMATION

This information is important for our records, your health, and may be required by new health policy laws

NAME_____**BIRTHDATE**_____RACE_____

ETHNICITY_____LANGUAGE_____HEIGHT_____ WEIGHT_____ SHOE SIZE_____

I. FOOT HISTORY

1. Describe your foot problem_____Which Foot? R___ L___

2. How long has it bothered you? Specify # _____ days _____ weeks _____ months _____ years

3. Any past problems with feet or ankles? _____

4. Any past surgical problems on your feet or ankles? _____

II. GENERAL HEALTH INFORMATION

1. Do you have Diabetes? ____ Yes ____ No How many years have you been diabetic?_____
   a. Do you take Insulin? ____ Yes ____ No Oral Medication _____ Diet Controlled _____
   b. Do any close relatives have diabetes? (mother, father, sister, brother) _____

2. Have you had any serious illnesses? _____

3. Have you had any major surgeries?_____

4. Are you currently receiving treatment by a physician for any medical problems? Yes_____ No ____

If yes, for what condition(s):_____

_____

5. Name of family physician_____ Phone #_____ Date you last saw doctor_____

6. Do you have prescription coverage? Yes ___ No ____ Copay amount_____ Pharmacy _____

III. ARE YOU ALLERGIC OR SENSITIVE TO:

Medications (please list) _____
Aspirin?_____ Tape? _____ Iodine? _____ Local Anesthetics? (Novacaine, Lidocaine)_____

IV. PERSONAL HISTORY

1. Do you smoke? Yes____ No____ # packs per day ( ) less than ½ ( ) 1 ( ) 1 ½ ( ) 2 ( ) 2+

   A. Have you quit smoking? Yes ____ No____ How long ago? _____

2. Do you drink alcohol or beer? Yes ____ No ____ # drinks per week ____ 1-2 per day 1-2 ____ per day > 3_____

3. Occupation_____ Retired?_____ Do You Mostly? ( ) sit ( ) stand ( )stand & walk

*******Please turn this page over and fill out additional information*******

V. MEDICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED OR UNDER A DOCTOR'S CARE FOR ANY OF THE FOLLOWING:

( ) Heart Attack	( ) COPD	( ) Bladder problems	( ) Glaucoma
( ) Congestive Heart Failure	( ) Lung problems	( ) Kidney problems	( ) Retinopathy
( ) High Blood Pressure	( ) Emphysema	( ) Kidney stones	( ) Rheumatic Fever
( ) Stroke	( ) Asthma	( ) Anemia	( ) Hormones
( ) Circulation Problems	( ) Gout	( ) Liver problem	( ) Skin Problems
( ) Cancer	( ) Intestinal Problem	( ) Tuberculosis	( ) Frequent Infections
( ) Diabetes	( ) Stomach Ulcer	( ) Hepatitis	( ) Problems Healing
( ) Arthritis	( ) Epilepsy or seizures	( ) Neurological Disorders	

( ) Others – Please List:_____

_____

1. Do you have any artificial joints? ( ) Hip ( ) Knee ( ) Other _____
2. Do you have a heart valve implant? ( ) Yes ( ) No
3. Are you currently pregnant? ( ) Yes ( ) No Due Date:_____

VI. SURGICAL HISTORY

	Y	N	Year		Y	N	Year
Foot Surgery:	( )	( )	_____	Heart/bypass:	( )	( )	_____
				Artery Surgery:	( )	( )	_____
Cataracts:	( )	( )	_____	Appendectomy:	( )	( )	_____
Gall Bladder:	( )	( )	_____	Hysterectomy:	( )	( )	_____
Prostate:	( )	( )	_____	Breast:	( )	( )	_____
Hip Surgery:	( )	( ) R L	_____	Knee Surgery:	( )	( ) R L	_____
Others: 1.			_____	4.			_____
2.			_____	5.			_____
3.			_____	6.			_____

VII. BROKEN BONES OR FRACTURES (OTHER THAN TOES & FINGERS)

Which Bone & Year Occurred

1. _____ 3. _____
2. _____ 4. _____