

## BRIEF MEDICAL HISTORY

Describe your foot problem:

ACCIDENT/INJURY RELATED? YES  NO

IF YES, IS IT WORK RELATED? YES  NO

DATE OF INJURY?

**PAST MEDICAL HISTORY** Do you have a history of any of the following?

**ARE YOU PREGNANT?** Yes  No

<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Gout	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Headache
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Hearing/Ear/Disorder
<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Nerve Disorder	<input type="checkbox"/> Keloid/Thick Scar
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Cancer Type:
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/>

**PLEASE LIST ALL MEDICATION NOW BEING TAKEN**

**DOSE**

**ALLERGIES**

		<input type="checkbox"/> NSAIDS	<input type="checkbox"/> Aspirin
		<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa drugs
		<input type="checkbox"/> Novacaine	<input type="checkbox"/> Anesthesia
		<input type="checkbox"/> Codeine	<input type="checkbox"/> Sedatives
		<input type="checkbox"/> Iodine	<input type="checkbox"/> Adhesives
		<input type="checkbox"/> Latex	<input type="checkbox"/> NONE
		<input type="checkbox"/> Other	

**PREVIOUS SURGERIES**

**Year**

**Surgeon/Hospital**


**FAMILY HISTORY**

PLEASE INDICATE: F=FATHER M=MOTHER S=SIBLING

**SOCIAL HISTORY**

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Foot Problems	Occupation:	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Attack	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure	Tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes Amount:
<input type="checkbox"/> Cancer	<input type="checkbox"/> Birth Defects	Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes Amount:

**REVIEW OF SYSTEMS** Please check if you **have** any of the following

<b>CONSTITUTIONAL</b>	<b>ENDOCRINE</b>	<b>CARDIOVASCULAR</b>	<b>GASTROINTESTINAL</b>
<input type="checkbox"/> Fever	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Chest pain (angina)	<input type="checkbox"/> Nausea
<input type="checkbox"/> Lethargy	<input type="checkbox"/> Frequent thirst	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Vomiting
<b>GENITOURINARY</b>	<input type="checkbox"/> Heat <input type="checkbox"/> Cold (intolerance)	<input type="checkbox"/> Cold extremities	<input type="checkbox"/> Constipation
<input type="checkbox"/> Frequent urination	<b>MUSCULOSKELETAL</b>	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Bloody/dark stool
<b>NEUROLOGICAL</b>	<input type="checkbox"/> Pain	<b>SKIN</b>	<input type="checkbox"/> Heartburn/GERD
<input type="checkbox"/> Headache	<input type="checkbox"/> Muscles <input type="checkbox"/> Neck	<input type="checkbox"/> Rash	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Fainting	<input type="checkbox"/> Back <input type="checkbox"/> Hips	<input type="checkbox"/> Itching	<b>HEMATOLOGICAL</b>
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Knees <input type="checkbox"/> Ankles	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Blood thinners
<input type="checkbox"/> Depression	<input type="checkbox"/> Feet	<input type="checkbox"/> Toenail/fingernail changes	<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Convulsion or seizure	<input type="checkbox"/> Limited range of motion	<input type="checkbox"/> Foot sores or skin lesions	<input type="checkbox"/> Blood abnormalities
<input type="checkbox"/> Numbness	<input type="checkbox"/> Limited strength	<input type="checkbox"/>	<input type="checkbox"/> Lymph node enlargement

**ANY PROBLEMS NOT LISTED**

**SIGNATURE**

**DATE**

**NAME:**

**AGE:**

**DATE OF BIRTH:**