NAME: **AGE:** **DATE OF BIRTH:**

BRIEF MEDICAL HISTORY

Describe your foot problem:

Preferred Pharmacy: Shoe Size:

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 ❑

❑ Alzheimer's	❑ Headache	❑ Kidney Disease ❑ Dialysis	❑ Psychiatric Disorder
❑ Anemia	❑ Hearing Disorder	❑ Liver Disease	❑ Sciatica
❑ Arthritis	❑ Heart Attack	❑ Lung Disease ❑ COPD	❑ Sleep Apnea
❑ Asthma	❑ Heart Condition	❑ MRSA	❑ Stroke
❑ Cancer Type:	❑ Hepatitis	❑ Nerve Disorder	❑ Thyroid Problem
❑ Diabetes	❑ High Blood Pressure	❑ Osteoporosis	❑ Tuberculosis
❑ Epilepsy	❑ HIV	❑ Phlebitis ❑ DVT	❑ Vascular Disease
❑ Gout	❑ Keloid/Thick Scar	❑ Poor Circulation	OTHER

PLEASE LIST ALL MEDICATION NOW BEING TAKEN **NONE ❑**	**DOSE**	**ALLERGIES**	
		❑ NSAIDS	❑ Aspirin
		❑ Penicillin	❑ Sulfa drugs
		❑ Novocain	❑ Anesthesia
		❑ Codeine	❑ Sedatives
		❑ Iodine	❑ Adhesives
		❑ Latex	❑ **NONE**
		❑ Other	

PREVIOUS SURGERIES **NONE ❑**	Year	Surgeon/Hospital

FAMILY HISTORY **PLEASE INDICATE: F=FATHER M=MOTHER S=SIBLING**		**SOCIAL HISTORY**		
❑ Diabetes	❑ Foot Problems	Occupation:		
❑ Arthritis	❑ Heart Attack	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed		
❑ Stroke	❑ High Blood Pressure	Tobacco	❑ No ❑ Yes	Amount:
❑ Cancer	❑ Birth Defects	Alcohol	❑ No ❑ Yes	Amount:

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

GENERAL	**RESPIRATORY**	**MUSCULOSKELETAL**	**PSYCHIATRIC**
❑ Fever	❑ Cough	❑Pain	❑ Depression
❑ Chills	❑ Difficulty Breathing	❑ Muscles ❑ Neck	❑ Anxiety
❑ Fatigue	**CARDIOVASCULAR**	❑ Back ❑ Hips	**ENDOCRINE**
❑ Weight Loss	❑ Shortness of Breath	❑ Knees ❑ Ankles ❑ Feet	❑ Night Sweats
❑ Weight Gain	❑ Chest Pain (Angina)	❑ Limited Range of Motion	❑ Frequent Urination
❑ Loss of Appetite	❑ Abnormal Heart Beat	❑ Limited Strength	❑ Frequent Thirst
SKIN	❑ Cold Extremities	❑ Leg Cramps	❑ Heat ❑ Cold (Intolerance)
❑ Rash	❑ Poor Circulation	**NEUROLOGICAL**	**HEMATOLOGICAL**
❑ Itching	**GASTROINTESTINAL**	❑ Headache	❑ Blood Thinners
❑ Dry Skin	❑ Diarrhea	❑ Dizziness ❑ Fainting	❑ Easy Bruising
❑ Toenail/Fingernail Changes	❑ Nausea ❑ Vomiting	❑ Seizures	❑ Blood Abnormalities
❑ Foot Sores or Skin Lesions	❑ Heartburn ❑ GERD	❑ Numbness	❑ Enlarged Lymph Nodes

ANY PROBLEMS NOT LISTED

SIGNATURE ***DATE***

FILL OUT COMPLETELY, INCLUDING SIGNATURE AND DATE