

NAME:

AGE:

DATE OF BIRTH:

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

PLEASE LIST ALL MEDICATION NOW BEING TAKEN NONE ☐**DOSE****ALLERGIES**

	<input type="checkbox"/> NSAIDS	<input type="checkbox"/> Aspirin
	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa drugs
	<input type="checkbox"/> Novocain	<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 NONE ☐**YEAR****SURGEON/HOSPITAL**

FAMILY HISTORY

Please indicate: F=Father M=Mother S=Sibling

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Foot Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Cancer	<input type="checkbox"/> Birth Defects

SOCIAL HISTORY

Occupation:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco ☐ No ☐ Yes Amount:

Alcohol ☐ No ☐ Yes Amount:

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

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

ANY PROBLEMS NOT LISTED**SIGNATURE****DATE**