MEDICAL HISTORY

Patient Name____ **Today's Date**_______________________________

What is your chief complaint for which you came to be treated? ____

Have you ever been to a Podiatrist? ☐ **Yes** ☐ **No If yes, please list: Name**__________________ **When**_______

Height__________ **Weight**__________ **Shoe Size**__________ **Your Occupation**_____________________________

Family Physician_________________________ **Phone Number**_________________ **Date of Last Visit**___________

Are you now, or have you been, under any doctor's care for any reason over the past two years? ☐ **Yes** ☐ **No**

If yes, please explain____

____

Surgeries you have had____

____

Athletic activities in which you participate (list activity and how often)______________________________________

____

Medications: Include prescription and over the counter medications____

____

Pharmacy Name _________________________________ **Pharmacy Phone**____________________________________

ALLERGIES	☐ Adhesive Tape	☐ Other Pain Meds	☐ Local Anesthetics	☐ Sulfa
PLEASE CHECK ANY	☐ Aspirin	☐ Latex	☐ Novocaine	☐ Other not listed
THAT MAY APPLY:	☐ Codeine	☐ Iodine	☐ Penicillin	__________________

Please place a mark on "Yes" or "No" to indicate if you have had any of the following:

Ankle Pain	☐ Yes ☐ No	**AIDS/HIV**	☐ Yes ☐ No	**Kidney Problems**	☐ Yes ☐ No
Athlete's Foot or Rash	☐ Yes ☐ No	**Anemia**	☐ Yes ☐ No	**Liver Disease**	☐ Yes ☐ No
Bunions	☐ Yes ☐ No	**Arthritis**	☐ Yes ☐ No	**Neuropathy**	☐ Yes ☐ No
Corns & Calluses	☐ Yes ☐ No	**Artificial Heart Valves**	☐ Yes ☐ No	**Phlebitis**	☐ Yes ☐ No
Cramps in Feet/Legs	☐ Yes ☐ No	**Back Problems**	☐ Yes ☐ No	**Psychiatric Care**	☐ Yes ☐ No
Flat Feet	☐ Yes ☐ No	**Bleeding Disorders**	☐ Yes ☐ No	**Rash**	☐ Yes ☐ No
Heel Pain	☐ Yes ☐ No	**Cancer**	☐ Yes ☐ No	**Respiratory Disease**	☐ Yes ☐ No
Ingrown Toenails	☐ Yes ☐ No	**Circulatory Problems**	☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No
Plantar (Foot) Warts	☐ Yes ☐ No	**Diabetes**	☐ Yes ☐ No	**Tuberculosis**	☐ Yes ☐ No
Numbness in Feet	☐ Yes ☐ No	☐ **Taking Medication or**	☐ **Insulin**	**Ulcers on Feet**	☐ Yes ☐ No
Swelling in Feet/Ankles	☐ Yes ☐ No	**Diabetic Family History**	☐ Yes ☐ No	**Ulcers (Stomach)**	☐ Yes ☐ No
Tired Feet	☐ Yes ☐ No	**Gout**	☐ Yes ☐ No	**Weight Loss --Unknown**	☐ Yes ☐ No
Foot Injury	☐ Yes ☐ No	**Heart Disease**	☐ Yes ☐ No	**Cigarette/Tobacco Use**	☐ Yes ☐ No
What and When____________________		**Hepatitis or Jaundice**	☐ Yes ☐ No	**Years Smoked**____________________	
______________________________		**High Blood Pressure**	☐ Yes ☐ No	**Per Day Usage Amount**________________	