MEDICAL HISTORY

Patient name:_____ Date of Birth: _____ Today's Date: _____

Foot complaint: _____ ☐ right ☐ left ☐ both

Have YOU ever had any of the following: (circle all that apply) ☐ None

High blood pressure	Diabetes	Thyroid problems
Heart attack	Peripheral neuropathy	Gout
Coronary bypass/stent	Peripheral vascular disease	Depression
Congestive heart failure	Foot ulcers/wounds	Anxiety disorder
Heart murmur	Arthritis (back, knees, hips, feet or other)	Leg swelling/edema
Pacemaker	Joint replacement	Varicose veins
Blood clotting disorder	Stroke	Heart surgery
DVT (deep venous thrombosis)	Paralysis	Orthopedic surgery
MRSA infection	Asthma	Previous chemotherapy
Chronic pain syndrome	COPD	Cancer surgery
Liver disease	Alcoholism	
Kidney disease	Cancer	
Dialysis	Fibromyalgia	

Other medical problems or surgeries please list here

_____

_____

Allergies: (circle all that apply) Adhesives/tape Latex Penicillin Iodine
Sulfa Aspirin Ibuprofen Anesthetic Agents
Other: _____ ☐ I have no known drug allergies

MEDICATIONS: please list here or ☐ I have brought a list to photocopy ☐ I take no medications

_____

_____

_____

_____

SOCIAL HISTORY: ☐ Single ☐ Married ☐ Widowed
☐ Employed ☐ Full-time ☐ Part-time ☐ Retired ☐ Don't work outside the home
☐ Current Smoker ☐ Former Smoker ☐ Non-Smoker

Approximate -- height _____ weight _____ Shoe Size _____