3. MEDICAL HISTORY: (Please Check if Positive)
__Diabetes mellitus
__High Blood pressure
__Heart condition: (Please describe):_____
__Lung, liver, or kidney problems:_____
__Stomach problems, ulcers, or intestinal problems
__Excessive bleeding __Anemia
__Blood clots in the lungs or legs
__Arthritis, rheumatism, or gout
__Raised scars or keloids __Frostbite __Hepatitis
__Stroke, epilepsy, or head injury

Allergies: (Check if positive)
__Penicillin __Iodine __Dental injections __Codeine __Sulfa
__Other: (List)_____

Please list all past surgeries or hospitalizations and dates:
_____

_____

Current medications and dosages (Bring a list if you don't know)
_____

_____

Social Habit (Please check where appropriate)
__Smoking __Packs Daily __Years Smoked _____Date Quit
__Alcohol Number of Drinks per week:__
__History of alcoholism? Yes__ No__
__History of substance abuse? Yes__ No__

Please list all medical problems requiring treatment suffered by all immediate family members. Use L=Living and D=deceased.
PROBLEM LISTING
__L __D Father:
__L __D Mother:
__L __D Brothers:
__L __D Sisters:
__L __D Children:
Childhood Illnesses (Check if you recall having any of these)
__Measles __Mumps __Whooping cough __German measles __Chicken pox
__Rheumatic fever__Herpes
Height:____ Weight:____ Shoe Size:____
Please describe your foot pain or problem in your own words: