PATIENT HISTORY

WHAT IS THE MAIN PROBLEM WITH YOUR FEET OR ANKLES:

____

WHEN DID THIS PROBLEM OCCUR:

____

HAVE YOU EVER HAD AN INJURY TO THE LOWER EXTREMITIES: YES or NO

IF SO EXPLAIN:

____

OCCUPATION:

____

PRIMARY CARE PHYSICIAN

NAME & PHONE #

____

DATE OF LAST PHYSICAL EXAM:

____

ARE YOU DIABETIC? YES or NO if so….. ARE YOU ON INSULIN YES or NO?

NAME & PHONE # OF THE DOCTOR WHO TREATS YOU FOR YOUR DIABETES:

____

PHARMACY NAME & NUMBER:

____

ALLERGIES: NONE PCN CODEINE SULFA LATEX DEMEROL CORTISONE ENVIRONMENTAL

____

WHAT TYPE OF REACTION:

____

MEDICATION	DOSAGE	REASON

DO YOU SMOKE: YES or NO DO YOU DRINK: YES or NO

MEDICAL HISTORY:

PLEASE MARK ALL THAT APPLY:

MARK (SELF) FOR YOURSELF (M) FOR MOM (D) FOR DAD (B) FOR BROTHER (S) FOR SISTER

DIABETES_____________ HEART DISEASE_____________

HIGH BLOOD PRESSURE_____________ CHOLOSTEROL_____________

COPD_________________ ASTHMA_____________

ARTHRITIS_____________ GOUT_______________

THYROID______________ CANCER_____________

OTHER____

SURGICAL HISTORY:

____

____

____

____

To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

PATIENT/QUARDIAN:

SIGNATURE: ____ DATE: ___________________________