MEDICAL INFORMATION
THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

DESCRIBE YOUR FOOT PROBLEM:

_____

_____

_____

Have you had any past problems with your feet and ankles?

_____

Have you had any past surgical procedures on your feet and ankles?

_____

What medications do you take regularly?

_____

_____

_____

_____

Please list any allergies or sensitivities to drugs, tape, anesthetics:

_____

_____

GENERAL HEALTH INORMATION

Do you have diabetes?_____Are you taking insulin?_____Number of years?_____

Please check () any of the following you have, or have had, a problem with:

( ) Heart	( ) Asthma	( ) Skin	( ) Circulation
( ) Gout	( ) Frequent Infections	( ) Arthritis	( ) Stomach Ulcers
( ) MRSA	( ) VRSA	( ) Tuberculosis	( ) Healing
( ) Anemia	( ) Neurological Disorder	( ) High Blood Pressure	( ) Cancer

Do you have any artificial joints?_____
Do you smoke? No____Yes____Packs per day____Previously smoked? No_____Yes____#of years____
Do you drink alcohol or beer? No_____Yes____How often?_____

Employment:
( ) Retired ( ) Sit at job ( ) Stand at job ( ) Stand & sit at job #of hours?_____

FAMILY HISTORY

Is there family (blood related) history of, if so, please list:

( ) Heart Disease_____ ( ) Stroke_____
( ) Diabetes_____ ( ) TB_____
( ) High Blood Pressure_____ ( ) Epilepsy_____
( ) Cancer_____
( ) Anemia_____

Primary Care Physician_____

Shoe Size_____

Signature_____Date_____