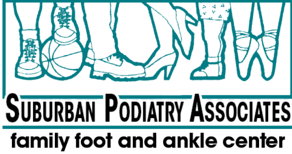

Medical History

Patient Name: ______________________________________ Date: ______________

Date of Birth: __________________ Age: _____

Height: ________ Weight: ________ BP: ______ / ______ Shoe Size: ________

Allergies: ☐penicillin ☐local anesthetics ☐General anesthesia

☐ latex ☐ adhesive tape ☐ iodine ☐other (please list) ______________________

Social History

Tobacco Use ☐yes ☐No If yes: ☐ daily ☐ occasional, Former Smoker: ☐ yes ☐ no

Alcohol Use ☐yes ☐No If yes, drinks per week ______

Married ☐ yes ☐ No

Family History

Father: ☐ living ☐ deceased ☐ Diseases (please list) ____

Mother:☐ living ☐ deceased ☐ Diseases (please list) ____

Past Medical History

(list past medical conditions) ____

Surgical History

Past surgeries: (please list) ____

Medications (please list all Prescription and non- Prescription Medications and dosages). ☐ **see attached list**

________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________

General Health: ☐Good ☐Fair ☐Poor

Diabetes: ☐yes ☐No If yes, last blood sugar: _______ Date : ____________

Last HgbA1C: _______ Date: _______________

Foot Condition

Describe todays Foot Problem: ____

Duration of Condition ____ days ____ weeks ____ months ____ years

Have you been treated by a Doctor for this condition ? ☐ yes ☐ no

List All Prior Treatment for todays Foot Problem: ____

Medical History (continued)

Patient Name: _______________________________ Date: ____________

Review of Systems (ROS)

(Please check each item that currently applies to you)

Constitutional (general):

☐ weight loss ☐ weight gain ☐ fever ☐ chills ☐ fatigue ☐ nausea

Head:

☐ headaches ☐ dizziness

Skin:

☐ skin cancer ☐ psoriasis ☐ eczema ☐ athletes foot ☐ warts

☐ moles/pigmented lesions ☐ new skin growths

Eyes:

☐ wear glasses ☐ glaucoma ☐ cataracts ☐ macular degeneration

Ears/Nose/Throat:

☐ hearing loss ☐ ear aches ☐ sinus condition ☐ recent sore throat ☐ tenitus

☐ nose bleeds ☐ swollen glands ☐ gum / mouth condition

Gastrointestinal:

☐ frequent heartburn ☐ Crohn's disease ☐ abdominal pain ☐ peptic/gastric ulcer

☐ diverticulosis ☐ cirrhosis ☐ colon cancer ☐ rectal bleeding

Respiratory:

☐ pneumonia ☐ emphysema ☐ asthma ☐ lung cancer

☐ tuberculosis ☐ bronchitis

Cardiovascular:

☐ heart disease ☐ hypertension ☐ PAD ☐ varicose veins ☐ high cholesterol

☐ pacemaker ☐ DVT (blood clot) ☐mitral valve prolapse ☐ coronary artery disease

☐ congestive heart failure

Endocrine:

☐ diabetes ☐ hyperthyroid disease ☐ Hypothyroidism

Genito-Urinary:

☐ Breast cancer ☐ kidney disease ☐ prostate cancer ☐ incontinance

Hemotological:

☐ anemia ☐ leukemia ☐ AIDS / HIV ☐ Taking blood thinners

☐ lymphoma

Neurological:

☐ neuropathy ☐ paralysis ☐ back / spinal condition

☐ neurological disease ☐ complex regional pain syndrome (CRPS) ☐ sciatica

Muskuloskeletal:

☐ arthritis ☐ Rheumatoid arthritis ☐ Osteoporosis ☐ prior injury

☐ Back pain ☐fibromyalgia ☐ osteoarthritis ☐ spinal stenosis ☐ herniated disc

☐ Joint replacement surgery: ___________________________

Location: eg. Knee, Hip

Patient Signature: ____________________________________ Date: __________________

☐ I certify that all information provided by myself in this medical history is true and accurate to the best of my knowledge.