

# MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ear Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Medicine or Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves or Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gastro-intestinal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling in Ankles, Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Phlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Surgeries you have had \_\_\_\_\_

Hospitalization other than for the surgeries listed \_\_\_\_\_

Family physician \_\_\_\_\_ Last visit date \_\_\_\_\_

Are you now, or have you been, under any other doctor's care for any reason over the past two years?  Yes  No

If yes, please explain \_\_\_\_\_

## MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins \_\_\_\_\_

Pharmacy Name(s) \_\_\_\_\_

Pharmacy Phone(s) \_\_\_\_\_

Do you take oral contraceptives?  Yes  No

## ALLERGIES

- |  |  |
|--|--|
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Aspirin       | <input type="checkbox"/> Novocaine         |
| <input type="checkbox"/> Codeine       | <input type="checkbox"/> Penicillin        |
| <input type="checkbox"/> Demerol       | <input type="checkbox"/> Seafoods          |
| <input type="checkbox"/> Food          | <input type="checkbox"/> Sulfa             |
| <input type="checkbox"/> Iodine        |  |
| Other _____                            |  |

## CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_