

Patient Medical History

Name _____ Date _____

Age _____ Height _____ Weight _____ Shoe Size _____

Describe your foot problem _____

Please check all of the following for which you are currently being treated, or have been treated for in the past:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Artificial Joints (Hip/Knee)	<input type="checkbox"/> Hepatitis (A/B/C)	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Anticoagulants/Blood Thinners	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> CVA/TIA/Stroke	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Cancer	<input type="checkbox"/> Immune Disorder	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Depression/Anxiety		<input type="checkbox"/> Other _____

Please list **ALL medications** you are taking (both prescription and over the counter), or provide a current list: _____

Please list all **allergies** to medications: _____

Please list **ALL surgeries** you have had: _____

Do you use tobacco products? yes no If yes, how many packs each day and for how many years? _____

Do you use alcohol products? yes no If yes, daily, weekly, monthly, socially

Do you drink caffeine products? yes no If yes, daily, occasional

Please list any medical conditions (Diabetes, HBP, Heart Trouble, Arthritis, etc) your family members (children, siblings, parents, aunts, uncles, grandparents) have / had _____

Please check all of the following that you are experiencing/or have recently experienced:

<input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> Hair loss/Thinning	<input type="checkbox"/> Urinate Frequently
<input type="checkbox"/> Appetite Loss	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Urinary Incontinence
<input type="checkbox"/> Constipation	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Vision Loss
<input type="checkbox"/> Depression	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Weight Gain
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Numbness	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Other _____
<input type="checkbox"/> Edema/Swelling	<input type="checkbox"/> Thirst	_____