

## MEDICAL HISTORY

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Have you ever been to a Podiatrist before? YES NO If yes, Name: \_\_\_\_\_

Is there any personal or family history of Diabetes? YES NO

Your Occupation: \_\_\_\_\_ Athletic Activities: \_\_\_\_\_

Cigarette/Tobacco Use: \_\_\_\_\_ Years Smoked: \_\_\_\_\_ Alcohol Use: \_\_\_\_\_

Please indicate which foot problems you now have or have had in the past:

	Yes	No		Yes	No		Yes	No
Ankle Pain			Athletes Foot			Bunions		
Corns/Calluses			Cramps/Numbness in Feet or Legs			Flat Feet		
Foot or Leg Cramps			Heel Pain			Ingrown Toenails		
Plantar Warts			Swelling in Ankles/Feet			Tired Feet		
Broken Foot/Ankle			Sprained Foot/Ankle					

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

	Yes	No		Yes	No		Yes	No
AIDS/HIV			Ear Problems			Psychiatric Care		
Allergies to Anesthetics			Epilepsy			Radiation Treatment		
Allergies to Medicines/Drugs			Eye Problems			Rash		
Anemia			Fainting			Respiratory Disease		
Angina			Gout			Rheumatic Fever		
Arthritis			Headaches			Shortness of Breath		
Artificial Heart Valves or Joints			Heart Disease			Sinus Problems		
Asthma			Hemophilia			Special Diet		
Back Problems			Hepatitis or Jaundice			Stroke		
Bleeding Disorders			High Blood Pressure			Swollen Neck Glands		
Cancer			Kidney Problems			Tuberculosis		
Chemical Dependency			Liver Disease			Ulcers		
Chest Pain			Low Blood Pressure			Varicose Veins		
Chronic Diarrhea			Neuropathy			Venereal Disease		
Circulatory Problems			Phlebitis			Weight Loss, Unexplained		
Diabetes								

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

Hospitalizations other than the surgeries listed above: \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_