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MEDICAL HISTORY

ANSWERS TO THE FOLLOWING QUESTIONS ARE CONFIDENTIAL

1A. ARE YOU IN GOOD HEALTH? YES NO
1B. HAS THERE BEEN A CHANGE IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR? YES NO

2. MY LAST PHYSICAL EXAM WAS ON ______________________________

3. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? YES NO

4. THE NAME AND ADDRESS OF MY PHYSICIAN IS

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5. HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATIONS? YES NO

6. HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE PAST 5 YEARS? YES NO

7. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

A. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE YES NO
B. CONGENITAL HEART LESIONS YES NO
C. CARDIOVASCULAR DISEASE (HEART TROUBLE, HEART ATTACK, CORONARY OCCLUSION , HIGH BLOOD PRESSURE, STROKE, ARTERIOSCLEROSIS) YES NO
C1. DO YOU HAVE PAIN IN CHEST UPON EXERTION YES NO
C2. ARE YOU EVER SHORT OF BREATH AFTER EXERCISE YES NO
C3. DO YOUR ANKLES SWELL YES NO
C4. DO YOU GET SHORT OF BREATH WHEN YOU LIE DOWN OR DO YOU REGUIRE EXTRA PILLOWS WHEN YOU SLEEP YES NO
D. ALLERGY YES NO
E. ASTHMA OR HAY FEVER YES NO
F. HIVES OR A SKIN RASH YES NO
G. FAINTING SPELLS OR SEIZURES YES NO
H. DIABETES YES NO
H1. DO YOU HAVE TO URINATE MORE THAN SIX TIMES A DAY YES NO
H2. ARE YOU THIRSTY MUCH OF THE TIME YES NO
H3. DOES YOU MOUTH FREQUENTLY BECOME DRY YES NO
I. HEPATITIS, JAUNDICE OR LIVER DISEASE YES NO
J. ARTHRITIS YES NO
K. INFLAMMATORY RHEUMATISM (SWOLLEN JOINTS) YES NO
L. STOMACH ULCERS YES NO

M. KIDNEY TROUBLE YES NO
N. TUBERCULOSIS YES NO
O. DO YOU HAVE A PERSISTENT COUGH OR COUGH UP BLOOD YES NO
P. LOW BLOOD PRESSURE YES NO
Q. VENEREAL DISEASE YES NO

8. HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS SURGERY OR TRAUMA YES NO
8A. DO YOU BRUISE EASILY YES NO
8B. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION YES NO
IF SO, EXPLAIN THE CIRCUMSTANCES ______________________

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9. DO YOU HAVE ANY BLOOD DISORDER SUCH AS ANEMIA YES NO
10. HAVE YOU HAD SURGERY OR X-RAY TREATMENT FOR TUMOR, GROWTH OR OTHER CONDITION OF YOU FEET YES NO
11. ARE YOU TAKING ANY DRUG OR MEDICINE YES NO

12. ARE YOU TAKING ANY OF THE FOLLOWING:
A. ANTIBIOTICS OR SULFA DRUGS YES NO
B. ANTICOAGULANTS (BLOOD THINNERS) YES NO
C. MEDICINE FOR HYPERTENSION YES NO
D. CORTISONE (STEROIDS) YES NO
E. TRANQUILIZERS YES NO
F. ASPIRIN YES NO
G. INSULIN, TOLBUTAMIDE (ORINASE) YES NO
H. DIGITALIS OR DRUGS FOR HEART CONDITION YES NO
I. NITROGLYCERIN YES NO
J. OTHER YES NO

13. ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:
A. LOCAL ANESTHETICS YES NO
B. PENICILLIN OR OTHER ANTIBOTICS YES NO
C. SULFA DRUGS YES NO
D. BARBITURATES, SEDATIVES OR SLEEPING PILLS YES NO
E. ASPIRIN YES NO
F. IODINE YES NO
G. OTHER ______________________

14. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS PODIATRIC TREATMENT? YES NO

15. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE? YES NO
IF YES, PLEASE EXPLAIN ______________________

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WOMEN
16. ARE YOU PREGNANT? YES NO

SIGNATURE OF PATIENT ______________________