# Medical History

Name:_____

My foot problem involves: ☐ R foot ☐ L foot ☐ both feet

Describe your foot problem(s): _____

_____

_____

_____

When did the problem begin?_____ Date (if an injury): _____

What has been done to treat the problem? _____

## ALLERGIES

| | |
|---|---|
| Adhesive Tape | ☐Y ☐N |
| Aspirin | ☐Y ☐N |
| Codeine | ☐Y ☐N |
| Demerol | ☐Y ☐N |
| Iodine | ☐Y ☐N |
| Latex | ☐Y ☐N |
| Local Anesthetics | ☐Y ☐N |
| Morphine | ☐Y ☐N |
| Novocaine | ☐Y ☐N |
| Penicillin | ☐Y ☐N |
| Sulfa | ☐Y ☐N |

Others:_____

_____

or CIRCLE: **No Known Allergies**

## CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

_____

**Please check Y (Yes) or N (No) to indicate if you have had a history of any of the following:**

| | |
|---|---|
| AIDS/HIV | ☐Y ☐N |
| Arthritis | ☐Y ☐N |
| Asthma | ☐Y ☐N |
| Bleeding Disorder | ☐Y ☐N |
| Cancer:_____ | ☐Y ☐N |
| Circulation Problem | ☐Y ☐N |
| Depression | ☐Y ☐N |
| Diabetes | |
| - diet controlled | ☐Y ☐N |
| - oral medication | ☐Y ☐N |
| - insulin dependent | ☐Y ☐N |
| Ear Problems | ☐Y ☐N |
| Emphysema | ☐Y ☐N |
| Epilepsy | ☐Y ☐N |
| Eye Problems | ☐Y ☐N |
| Fibromyalgia | ☐Y ☐N |
| Foot Ulcers | ☐Y ☐N |
| Gout | ☐Y ☐N |
| Heart Attack | ☐Y ☐N |
| Heart Disease | ☐Y ☐N |
| Hepatitis | ☐Y ☐N |
| Herpes | ☐Y ☐N |
| High Blood Pressure | ☐Y ☐N |
| Kidney Disease | ☐Y ☐N |
| Liver Disease | ☐Y ☐N |
| Lung Disease | ☐Y ☐N |
| Mental Health Cond. | ☐Y ☐N |
| Multiple Sclerosis | ☐Y ☐N |
| Phlebitis | ☐Y ☐N |
| Pneumonia | ☐Y ☐N |
| Rheumatic Fever | ☐Y ☐N |
| Sciatica | ☐Y ☐N |
| Skin Condition | ☐Y ☐N |
| Stomach Ulcer | ☐Y ☐N |
| Stroke | ☐Y ☐N |
| Thyroid Condition | ☐Y ☐N |
| Venereal Disease | ☐Y ☐N |

**Please list *any other* medical problems:**

_____

_____

_____

_____

_____

***Women Only:***

Are you pregnant? ☐Y ☐N

Breast Feeding? ☐Y ☐N

## PODIATRIC HISTORY:

Previous Foot or Ankle problems, injuries & treatment?

_____

_____

_____

_____

_____

_____

## PREVIOUS SURGERIES:

None

Yes (If yes, list below)

_____

_____

_____

_____

_____

_____

**Is there a <u>FAMILY HISTORY</u> of following medical problems?**
*(<u>List relationship to you</u>)*

Arthritis _____

Bunions _____

Cancer _____

Diabetes _____

Flat feet _____

Heart Disease _____

Hypertension _____

Stroke _____

Others:_____

_____

_____

**Do you smoke?** ☐Y ☐N

If yes, how much?

_____

**Do you drink alcohol?**
(*Circle one*)

None Rarely Weekly
Moderately Daily Quit