

Medical History

Please complete the following information which will assist in determining an accurate diagnosis and proper course of treatment

Patient's Name		Date of Birth	Age	Today's Date	Case (office to assign No.)
Residence Address		City	State	Zip	Daytime Phone No.
Family Physician's Name					Phone No.

My foot problem involves my Right Foot Left Foot Both Feet

Describe your foot problem: _____

	Yes	No	Please Explain
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any serious illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any major operations?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you under a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>	
May we contact your physician about your health?	<input type="checkbox"/>	<input type="checkbox"/>	
What medications and dosages are you currently taking?			

Check (x) any of the following you have or have had a problem with:

<p>GENERAL MEDICAL HISTORY:</p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Arthritis <input type="checkbox"/> Circulation <input type="checkbox"/> Gout <input type="checkbox"/> Anemia <input type="checkbox"/> Asthma <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Hardening of Arteries <input type="checkbox"/> Infection Prone <input type="checkbox"/> Bleed Easy <input type="checkbox"/> Slow Healer <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Kidney Trouble <input type="checkbox"/> Liver Trouble <input type="checkbox"/> Fainting Spells	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Polio <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Cancer <input type="checkbox"/> Epilepsy <input type="checkbox"/> Gangrene <input type="checkbox"/> Drug Allergies <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <p>FOOT & LEG CONDITIONS</p> <input type="checkbox"/> Bunlons <input type="checkbox"/> Bone Fracture <input type="checkbox"/> Bow Legs <input type="checkbox"/> Burning <input type="checkbox"/> Arch Pain	<input type="checkbox"/> Foot Cramps <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Unequal Leg Length <input type="checkbox"/> Knee Pain <input type="checkbox"/> Heel Pain <input type="checkbox"/> Knocked Knees <input type="checkbox"/> Sprains <input type="checkbox"/> Weak Ankles <input type="checkbox"/> Swelling <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Nerve Injury <input type="checkbox"/> Stiffness <input type="checkbox"/> Coldness <input type="checkbox"/> Numbness <input type="checkbox"/> Pigeon Toes	<input type="checkbox"/> Toes Outward <input type="checkbox"/> Flat Feet <input type="checkbox"/> High Arches <input type="checkbox"/> Hammer Toes <input type="checkbox"/> Other: <input type="checkbox"/> Other: <p>FOOT SKIN PROBLEMS</p> <input type="checkbox"/> Fungus <input type="checkbox"/> Growths <input type="checkbox"/> Hard Corns <input type="checkbox"/> Soft Corns <input type="checkbox"/> Dryness <input type="checkbox"/> Calluses <input type="checkbox"/> Moist Skin <input type="checkbox"/> Other: <input type="checkbox"/> Other:	<p>TOENAIL PROBLEMS</p> <input type="checkbox"/> Fungus <input type="checkbox"/> Thick <input type="checkbox"/> Curved <input type="checkbox"/> Ingrown <input type="checkbox"/> Brittle <input type="checkbox"/> Deformed <input type="checkbox"/> Discolored <input type="checkbox"/> Other: <p>SHOE WEAR PROBLEM</p> <input type="checkbox"/> Tip <input type="checkbox"/> Heel <input type="checkbox"/> Upper <input type="checkbox"/> Soles <input type="checkbox"/> Other: <input type="checkbox"/> Other:
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Any additional information you wish us to know:

Are you allergic to or sensitive to:

I hereby give Dr. _____ permission to examine and treat my feet.

Signature: _____

Patient, parent or guardian (if patient is a minor)

	Yes	No
Novacaine	<input type="checkbox"/>	<input type="checkbox"/>
Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>
Fabric	<input type="checkbox"/>	<input type="checkbox"/>
Foods	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what _____		

Summary (Doctor's use),